Nos. 89-1391, 1392

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, ET AL., *Petitioners*,

—v.—

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services, *Respondent*.

THE STATE OF NEW YORK, ET AL., *Petitioners*,

—v.—

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services, *Respondent*.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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Excerpts From Affidavits

The following items are not reprinted in this Joint Appendix because they appear, in full or in part, on the pages indicated in the Appendix to the Petition for Writ of Certiorari (__a) or in The Supplement to the Petition for Writ of Certiorari (__sa).

Excerpts from:

Additional Materials

RELEVANT DOCKET ENTRIES FOR *RUST v. SULLIVAN* AND *NEW YORK v. SULLIVAN*

Date	*Proceedings*
2-2-88	*Rust* Complaint - Class Action (S.D.N.Y.) (88-702)
2-2-88	*New York* Complaint (S.D.N.Y.) (88-701)
2-8-88	*Rust* Motion for Preliminary Injunction
2-9-88	*New York* Motion for Preliminary Injuction
2-17-88	Defendant's Motion to Dismiss *Rust* and *New York*
2-19-88	Stipulation of Consolidation of *Rust* and *New York*
3-1-88	Order Granting Plaintiffs' Motion for Preliminary Injunction
3-4-88	Plaintiffs' Cross-Motion for Summary Judgment
4-4-88	Plaintiffs' Motion for Class Certification
4-12-88	Stipulation Staying Motion for Class Certification

Title X, Public Health Service Act, 42 U.S.C. §§ 300-300a-6a (1982)

SUBCHAPTER VIII -- POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

§ 300. Project grants and contracts for family planning services

(a) Authority of Secretary

The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practical, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this subsection.

(b) Factors determining awards; establishment and preservation of rights of local and regional entities

In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance. Local and regional entities shall be assured the right to apply for direct grants and contracts under this section, and the Secretary shall by regulation fully provide for and protect such right.

(c) Authorization of appropriations

For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; $111,500,000 for the fiscal year ending June 30, 1973; $111,500,000 each for the fiscal years ending June 30, 1974 and June 30, 1975; $115,000,000 for fiscal year 1976; $115,000,000 for the fiscal year ending September 30, 1977; $136,400,000 for the fiscal year ending September 30, 1978; $200,000,000 for the fiscal year ending September 30, 1979; $230,000,000 for the fiscal year ending September 30, 1980; $264,500,000 for the fiscal year ending September 30, 1981; $126,510,000 for the fiscal year ending September 30, 1982; $139,200,000 for the fiscal year ending September 30, 1983; and $150,830,000 for the fiscal year ending September 30, 1984.

* * * *

§ 300a. Formula grants to States for family planning services

(a) Authority of Secretary; prerequisites

The Secretary is authorized to make grants, from allotments made under subsection (b) of this section, to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services.

(b) Factors determining amount of State allotments

The sums appropriated to carry out the provisions of this section shall be allotted to the States by the Secretary on the basis of the population and the financial need of the respective States.

(c) "State" defined

For the purposes of this section, the term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Virgin Islands, the District of Columbia, and the Trust Territory of the Pacific Islands.

(d) Authorization of appropriations

For the purpose of making grants under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $15,000,000 for the fiscal year ending June 30, 1972; and $20,000,000 for the fiscal year ending June 30, 1973.

* * * *

§ 300a-1. Training grants and contracts; authorization of appropriations

(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contract with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 300 or 300a of this title.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; $4,000,000 for the fiscal year ending June 30, 1973; $3,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $4,000,000 for fiscal year 1976; $5,000,000 for the fiscal year ending September 30, 1977; $3,000,000 for the fiscal year ending September 30, 1978; $3,100,000 for the fiscal year ending September 30, 1979; $3,600,000 for the fiscal year ending September 30, 1980; $4,100,000 for the fiscal year ending September 30, 1981; $2,920,000 for the fiscal year ending September 30. 1982; $3,200,000 for the fiscal year ending September 30, 1983; and $3,500,000 for the fiscal year ending September 30, 1984.

* * * *

§ 300a-2. Conduct, etc., of research activities

The Secretary may --

(1) conduct, and

(2) make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for, research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

* * * *

§ 300a-3. Informational and educational materials development grants and contracts; authorization of appropriations

(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; $1,250,000 for the fiscal year ending June 30, 1973; $909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $2,000,000 for fiscal year 1976; $2,500,000 for the fiscal year ending September 30, 1977; $600,000 for the fiscal year ending September 30, 1978; $700,000 for the fiscal year ending September 30, 1979; $805,000 for the fiscal year ending September 30, 1980; $926,000 for the fiscal year ending September 30, 1981; $570,000 for the fiscal year ending September 30, 1982; $600,000 for the fiscal year ending September 30, 1983; and $670,000 for the fiscal year ending September 30, 1984.

* * * *

§ 300a-4. Grants and contracts

(a) Promulgation of regulations governing execution; amount of grants

Grants and contracts made under this subchapter shall be made in accordance with such regulations as the Secretary may promulgate. The amount of any grant under any section of this subchapter shall be determined by the Secretary; except that no grant under any such section for any program or project for a fiscal year beginning after June 30, 1975, may be made for less than 90 per centum of its costs (as determined under regulations of the Secretary) unless the grant is to be made for a program or project for which a grant was made (under the same section) for the fiscal year ending June 30, 1975, for less than 90 per centum of its costs (as so determined), in which case a grant under such section for that program or project for a fiscal year beginning after that date may be made for a percentage which shall not be less than the percentage of its costs for which the fiscal year 1975 grant was made.

(b) Payment of grants

Grants under this subchapter shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

(c) Prerequisites; "low-income family" defined

A grant may be made or contract entered into under section 300 or 300a of this title for a family planning service project or program only upon assurances

satisfactory to the Secretary that --

(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge.

For purposes of this subsection, the term "low-income family" shall be defined by the Secretary in accordance with such criteria as he may prescribe so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this subchapter.

(d) Suitability of informational or educational materials

(1) A grant may be made or a contract entered into under section 300 or 300a-3 of this title only upon assurances satisfactory to the Secretary that informational or educational materials developed or made available under the grant or contract will be suitable for the purposes of this subchapter and for the population or community to which they are to be made available, taking into account the educational and cultural background of the individuals to whom such materials are addressed and the standards of such population or community with respect to such materials.

(2) In the case of any grant or contract under section 300 of this title, such assurances shall provide for the review and approval of the suitability of such materials, prior to their distribution, by an advisory committee established by the grantee or contractor in accordance with the Secretary's regulations. Such a

committee shall include individuals broadly representative of the population or community to which the materials are to be made available.

* * * *

§ 300a-5. Voluntary participation by individuals; participation not prerequisite for eligibility or receipt of other services and information

The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this subchapter (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.

* * * *

§ 300a-6. Prohibition against funding programs using abortion as family planning method

None of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.

* * * *

§ 300a-6a. Plans and reports

(a) Submission of report to Congress; purposes of plan

Not later than seven months after the close of each fiscal year, the Secretary shall make a report to the Congress setting forth a plan to be carried out over the next five fiscal years for --

(1) extension of family planning services to all persons desiring such services,

(2) family planning and population research programs,

(3) training of necessary manpower for the programs authorized by this subchapter and other Federal laws for which the Secretary has responsibility and which pertain to family planning, and

(4) carrying out the other purposes set forth in this subchapter and the Family Planning Services and Population Research Act of 1970.

(b) Minimum requirements for plan

Such a plan shall, at a minimum, indicate on a phased basis --

(1) the number of individuals to be served by family planning programs under this subchapter and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet the purposes of this subchapter and other Federal laws for which the

Secretary has responsibility and which pertain to family planning programs; and

(3) the steps to be taken to maintain a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health and Human Services shall be based.

(c) Contents of report

Each report submitted under subsection (a) of this section shall --

(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan contained in the previous such report;

(2) indicate steps being taken to achieve the objectives during the fiscal years covered by the plan contained in such report and any revisions to plans in previous reports necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan contained in such report.

* * * *

Title X, Public Health Service Act, 42 U.S.C.A. §§ 300-300a-7 (West Supp. 1990)

SUBCHAPTER VIII -- POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

§ 300. Project grants and contracts for family planning services

[See main volume for text of (a) and (b)]

(c) Reduction of grant amount

The Secretary, at the request of a recipient of a grant under subsection (a) of this section, may reduce the amount of such grant by the fair market value of any supplies or equipment furnished the grant recipient by the Secretary. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment on which the reduction of such grant is based. Such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

(d) Authorization of appropriations

For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; $111,500,000 for the fiscal year ending June 30, 1973; $111,500,000 each for the fiscal years ending June 30, 1974 and June 30, 1975; $115,000,000 for fiscal year 1976; $115,000,000 for the fiscal year ending September 30, 1977; $136,400,000 for the fiscal year ending

September 30, 1978; $200,000,000 for the fiscal year ending September 30, 1979; $230,000,000 for the fiscal year ending September 30, 1980; $264,500,000 for the fiscal year ending September 30, 1981; $126,510,000 for the fiscal year ending September 30, 1982; $139,200,000 for the fiscal year ending September 30, 1983; $150,830,000 for the fiscal year ending September 30, 1984; and $158,400,000 for the fiscal year ending September 30, 1985.

* * * *

§ 300a-1. Training grants and contracts: authorization of appropriations

[See main volume for text of (a)]

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; $4,000,000 for the fiscal year ending June 30, 1973; $3,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $4,000,000 for fiscal year 1976; $5,000,000 for the fiscal year ending September 30, 1977; $3,000,000 for the fiscal year ending September 30, 1978; $3,100,000 for the fiscal year ending September 30, 1979; $3,600,000 for the fiscal year ending September 30, 1980; $4,100,000 for the fiscal year ending September 30, 1981, $2,920,000 for the fiscal year ending September 30. 1982; $3,200,000 for the fiscal year ending September 30, 1983; $3,500,000 for the fiscal year ending September 30, 1984; and $3,500,000 for the fiscal year ending September 30, 1985.

* * * *

§ 300a-3. Informational and educational materials development grants and contracts; authorization of appropriations

[See main volume for text of (a)]

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; $1,250,000 for the fiscal year ending June 30, 1973; $909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $2,000,000 for fiscal year 1976; $2,500,000 for the fiscal year ending September 30, 1977; $600,000 for the fiscal year ending September 30, 1978; $700,000 for the fiscal year ending September 30, 1979; $805,000 for the fiscal year ending September 30, 1980; $926,000 for the fiscal year ending September 30, 1981; $570,000 for the fiscal year ending September 30, 1982; $600,000 for the fiscal year ending September 30, 1983; $670,000 for the fiscal year ending September 30, 1984; and $700,000 for the fiscal year ending September 30, 1985.

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§ 300a-4. Grants and contracts

[See main volume for text of section]

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§ 300a-6. Prohibition against funding programs using abortion as family planning method

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§ 300a-7. Sterilization or abortion

(a) Omitted

(b) Prohibition of public officials and public authorities from imposition of certain requirements contrary to religious beliefs or moral convictions

The receipt of any grant, contract, loan or loan guarantee under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], the Community Mental Health Centers Act [42 U.S.C.A. § 2689 et seq.], or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C.A. § 6000 et seq.] by any individual or entity does not authorize any court or any public official or other public authority to require --

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if the performance of such procedure or abortion if his performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to --

(A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the

performance or assistance in the performance of such procedures or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

(c) Discrimination prohibition

(1) No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], the Community Mental Health Centers Act [42 U.S.C.A. § 2689 et seq.], or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C.A. § 6000 et seq.] after June 18, 1973 may --

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,

because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.

(2) No entity which receives after July 12, 1974, a grant or contract for biomedical or behavioral research under any program administered by the Secretary of

Health and Human Services may --

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,

because he performed or assisted in the performance of any lawful health service or research activity, because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance or assistance in the performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting any such service or activity.

(d) Individual rights respecting certain requirements contrary to religious beliefs or moral convictions

No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

(e) Prohibition on entities receiving Federal grant, etc. from discriminating against applicants for training or study because of refusal of applicant to participate on religious or moral grounds

No entity which receives, after September 29, 1979, any grant, contract, loan, loan guarantee, or interest subsidy under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], the Community Mental Health Centers Act [42 U.S.C.A. § 2689 et seq.], or the Developmental Disabilities Assistance Bill of Rights Act [42 U.S.C.A. § 6000 et seq.] may deny admission or otherwise discriminate against any applicant (including applicants for internships and residencies) for training or study because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

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Regulations Governing Grants for Family Planning Services, 36 Fed. Reg. 18465 (1971)

Subpart A -- Project Grants for Family Planning Services

* * * *

§ 59.5 Project requirements

An approvable application must contain each of the following unless the Secretary determines that the applicant has established good cause for its omission:

(a) Assurances that:

(1) Services will be made available without the imposition of any durational residence or referral requirement;

(2) Services will be made available without regard to religion, creed, age, sex, parity, or marital status;

(3) Services will be made available in such a manner as to protect the dignity of the individual;

(4) Priority in the provision of services will be given to persons from low-income families;

(5) No charge will be made for services provided to any person from a low income family except to the extent that payment will be made by a third party (including a Government agency) which is authorized or is under legal obligation to pay such charge. In such case, effort must be made to obtain such third party payments. Where the cost of services is to be reimbursed under title XIX of the Social Security Act, a written agreement with the title XIX agency is required. Reimbursement may be either to the project or in lieu thereof directly to the provider in accordance with the above referred to written agreement. Charges to be

made for services to persons other than those from low income families must be in accordance with a schedule submitted and approved as part of the project plan;

(6) Family planning medical services will be performed under the direction of a physician with special training or experience in family planning;

(7) All services purchased for project participants will be authorized by the Project Director or his designee on the project staff;

(8) Services provided will be solely on a voluntary basis and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other programs of the applicant; and

(9) The project will not provide abortions as a method of family planning.

(b) A description of how persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of the project and will be given an opportunity to participate in the implementation and evaluation of such project.

(c) Provision for pre- and in-service training for all project personnel.

(d) Provision for medical services related to family planning including physician's consultation, examination, prescription, continuing supervision, laboratory examination, contraceptive supplies, and necessary referral to other medical facilities when medically indicated.

(e) Provision for social services related to family planning, including counseling, referral to and from other social and medical services agencies, and such ancillary services as are necessary to facilitate clinic attendance.

(f) Provision for the effective usage of contraceptive devices and practices.

(g) Provision for use of a broad range of medically approved methods of family planning including the rhythm method.

(h) Provision for diagnostic and treatment services for infertility.

(i) Provision for coordination and use of referral arrangements with other providers of health care services, with local health and welfare departments, hospitals, and voluntary agencies, and health services projects supported by other Federal programs.

(j) Provision for informational and educational programs designed to achieve community understanding of the objectives of the program, to inform the community of the availability of services, and to promote continuing participation in the project by persons to whom family planning services may be beneficial.

(k) In those cases in which the project will provide family planning services by contract or other similar arrangement with the actual providers of services, a plan shall be provided establishing rates and methods of payment for medical care. Such payments must be made pursuant to agreements with a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate that rates are reasonable and necessary.

(l) A description of the standards and qualifications which will be required for personnel (including the project director) and facilities utilized in the various aspects of carrying out the project plan.

* * * *

Regulations Governing Grants For Family Planning Services, 42 C.F.R. §§ 59.1-59.13 (1986)

PART 59 -- GRANTS FOR FAMILY PLANNING SERVICES

Subpart A -- Project Grants for Family Planning Services

AUTHORITY: Sec. 6(c), 84 Stat. 1507, 42 U.S.C. 300a-4; sec. 6(c), 84 Stat. 1506, 42 U.S.C. 300.

SOURCE: 45 FR 37436, June 3, 1980, unless otherwise noted.

§ 59.1 To what programs do these regulations apply?

The regulations of this subpart are applicable to the award of grants under section 1001 of the Public Health Service Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects. These projects shall consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children.

§ 59.2 Definitions.

As used in this subpart:

"Act" means the Public Health Service Act, as amended.

"Family" means a social unit composed of one person, or two or more persons living together, as a household.

"Low income family" means a family whose total annual income does not exceed 100 percent of the most

recent Community Services Administration Income Poverty Guidelines (45 CFR 1060.2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources.

"Nonprofit," as applied to any private agency, institution, or organization, means that no part of the entity's net earnings benefit, or may lawfully benefit, any private shareholder or individual.

"Secretary" means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

"State" means one of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, Northern Marianas, or the Trust Territory of the Pacific Islands.

[45 FR 37436, June 3, 1980, as amended at 48 FR 3614, Jan. 26, 1983; 49 FR 38118, Sept. 27, 1984]

§ 59.3 Who is eligible to apply for a family planning services grant?

Any public or nonprofit private entity in a State may apply for a grant under this subpart.

§ 59.4 How does one apply for a family planning services grant?

(a) Application for a grant under this subpart shall be made on an authorized form.

(b) An individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain --

(1) A description, satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

§ 59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents). If an organization offers only a single method of family planning, such as natural family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services.

(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other service, assistance from or

participation in any other program of the applicant.[1]

(3) Provide services in a manner which protects the dignity of the individual.

(4) Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

(5) Not provide abortions as a method of family planning.

(6) Provide that priority in the provision of services will be given to persons from low-income families.

(7) Provide that no charge will be made for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a Government agency) which is authorized to or is under legal obligation to pay this charge.

(8) Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent CSA Income Poverty Guidelines (45 CFR 1060.2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

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[1] Section 205 of Pub. L. 94-63 states: "Any (1) officer or employee of the United States, (2) officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or (3) person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both."

(9) If a third party (including a Government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX or title XX of the Social Security Act, a written agreement with the title XIX or title XX agency is required.

(10)(i) Provide that if an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential subgrantees which have previously provided or propose to provide family planning services to the area proposed to be served by the applicant.

(ii) Provide an opportunity for maximum participation by existing or potential subgrantees in the ongoing policy decisionmaking of the project.

(11) Provide for an Advisory Committee as required by § 59.6.

(b) In addition to the requirements of paragraph (a) of this section, each project must meet each of the following requirements unless the Secretary determines that the project has established good cause for its omission. Each project must:

(1) Provide for medical services related to family planning (including physician's consultation, examination prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family

planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for informational and educational programs designed to (i) achieve community understanding of the objectives of the program, (ii) inform the community of the availability of services, and (iii) promote continued participation in the project by persons to whom family planning services may be beneficial.

(4) Provide for orientation and in-service training for all project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

(6) Provide that family planning medical services will be performed under the direction of a physician with special training or experience in family planning.

(7) Provide that all services purchased for project participants will be authorized by the project director or his designee on the project staff.

(8) Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and methods of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

(Sec. 215, Public Health Service Act, 58 Stat. 690, 42 U.S.C. 216; sec. 1006(a), Public Health Service Act, 84 Stat. 1507, 42 U.S.C. 300a - 4(a); sec. 931(b)(1) of Pub. L. 97-35, 95 Stat. 570, 42 U.S.C. 300(a)) [45 FR 37436, June 3, 1980, as amended at 49 FR 38118, Sept. 27, 1984]

§ 59.6 What procedures apply to assure the suitability of informational and educational material?

(a) A grant under this section may be made only upon assurances satisfactory to the Secretary that the project shall provide for the review and approval of informational and educational materials developed or made available under the project by an Advisory Committee prior to their distribution, to assure that the materials are suitable for the population or community to which they are to be made available and the purposes of title X of the Act. The project shall not disseminate any such materials which are not approved by the Advisory Committee.

(b) The Advisory Committee referred to in paragraph (a) of this section shall be established as follows:

(1) *Size.* The Committee shall consist of no fewer than five but no more than nine members, except that this provision may be waived by the Secretary for good cause shown.

(2) *Composition.* The Committee shall include individuals broadly representative (in terms of demographic factors such as race, color, national origin, handicapped condition, sex, and age) of population or community for which the materials are intended.

(3) *Function.* In reviewing materials, the Advisory Committee shall:

(i) Consider the educational and cultural backgrounds of individuals to whom the materials are addressed;

(ii) Consider the standards of the population or community to be served with respect to such materials;

(iii) Review the content of the material to assure that the information is factually correct;

(iv) Determine whether the material is suitable for the population or community to which it is to be made available; and

(v) Establish a written record of its determinations.

§ 59.7 What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and in what amount?

(a) Within the limits of funds available for these purposes, the Secretary may award grants for the establishment and operation of those projects which will in the Department's judgment best promote the purposes of section 1001 of the Act, taking into account:

(1) The number of patients and, in particular, the number of low-income patients to be served;

(2) The extent to which family planning services are needed locally;

(3) The relative need of the applicant;

(4) The capacity of the applicant to make rapid and effective use of the Federal assistance;

(5) The adequacy of the applicant's facilities and staff;

(6) The relative availability of non-Federal resources within the community to be served and the degree to which those resources are committed to the project; and

(7) The degree to which the project plan adequately provides for the requirements set forth in these regulations.

(b) The Secretary shall determine the amount of any award on the basis of his estimate of the sum necessary for the performance of the project. No grant may be made for less than 90 percent of the project's costs, as so estimated, unless the grant is to be made for a project which was supported, under section 1001, for less than 90 percent of its costs in fiscal year 1975. In that case, the grant shall not be for less than the percentage of costs covered by the grant in fiscal year 1975.

(c) No grant may be made for an amount equal to 100 percent of the project's estimated costs.

§ 59.8 How is a grant awarded?

(a) The notice of grant award specifies how long HHS intends to support the project without requiring the project to recompete for funds. This period, called the project period, will usually be for 3 to 5 years.

(b) Generally the grant will initially be for 1 year and subsequent continuation awards will also be for 1 year at a time. A grantee must submit a separate application to have the support continued for each subsequent year. Decisions regarding continuation awards and the funding level of such awards will be made after consideration of such factors as the grantee's progress and management practices, and the availability

of funds. In all cases, continuation awards require a determination by HHS that continued funding is in the best interest of the Government.

(c) Neither the approval of any application nor the award of any grant commits or obligates the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved application or portion of an approved application.

§ 59.9 For what purpose may grant funds be used?

Any funds granted under this subpart shall be expended solely for the purpose for which the funds were granted in accordance with the approved application and budget, the regulations of this subpart, the terms and conditions of the award, and the applicable cost principles prescribed in Subpart Q of 45 CFR Part 74.

§ 59.10 What other HHS regulations apply to grants under this subpart?

Attention is drawn to the following HHS Department-wide regulations which apply to grants under this subpart: These include:

42 CFR Part 50, Subpart D -- Public Health Service grant appeals procedure
42 CFR Part 122, Subpart E -- Health Systems Agency review of certain proposed uses of Federal health funds
45 CFR Part 16 -- Procedures of the Departmental Grant Appeals Board
45 CFR Part 19 -- Limitations on payment or reimbursement for drugs
45 CFR Part 74 -- Administration of grants

45 CFR Part 80 -- Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964
45 CFR Part 81 -- Practice and procedure for hearings under Part 80 of this Title
45 CFR Part 84 -- Nondiscrimination on the basis of handicap in programs and activities receiving or benefiting from Federal financial assistance
45 CFR Part 91 -- Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance

[49 FR 38116, Sept. 27, 1984]

§ 59.11 Confidentiality.

All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.

§ 59.12 Inventions or discoveries.

(a) A project grant award is subject to the regulations of HHS as set forth in 45 CFR Parts 6 and 8, as amended. These regulations shall apply to any activity of the project for which grant funds are used, whether the activity is part of an approved project or is an unexpected byproduct of that project.

(b) The grantee and the Secretary shall take

appropriate measures to assure that no contracts, assignments, or other arrangements inconsistent with the grant obligation are continued or entered into and that all personnel involved in the grant activity are aware of and comply with such obligations.

§ 59.13 Additional conditions.

The Secretary may, with respect to any grant, impose additional conditions prior to or at the time of any award, when in the Department's judgment these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds.

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Memorandum from Joel M. Mangel, Deputy Assistant General Counsel, to Louis M. Hellman, M.D., Deputy Assistant Secretary for Population Affairs (Apr. 20, 1971)

MEMORANDUM

TO : Louis M. Hellman, M.D.
Deputy Assistant Secretary for Population Affairs

FROM : Joel M. Mangel
Deputy Assistant General Counsel
Division of Public Health Grants and Services

SUBJECT : Abortion as a Method of Family Planning--Section 1008 of the Public Health Service Act

You have orally asked us the following questions:

1. May a grant under Title X of the PHS Act, added by the Family Planning Services and Population Research Act of 1970, be made to an organization which, in addition to the provision of preventive family planning services, also provides, without Federal support, as part of its activities, abortion services as a method of family planning?

2. May grants under Title X be made to support research into fertility control methods which may prove to work in the manner of abortifacients?

3. May grants under Title X be made for the collection of data relating to the subject of abortion, for example a study of its effectiveness as a method of family planning?

Section 1008 of the Act provides:

> "None of the funds appropriated under this title [Title X] shall be used in programs where abortion is a method of family planning."

Although not entirely free from doubt, read literally the phrase "programs where abortion is a method of family planning," most reasonably limits the prohibition contained in section 1008 to the financial support of programs in which abortions are provided as a method of family planing.

However, because section 1008 is somewhat unclear and susceptible of other interpretations, we think that the legislative history of this provision is relevant to consideration of the questions presented.

The most significant expression of Congressional intent in this connection is contained in the Conference Report accompanying S. 2108, which contains the following statement:

> "It is, and has been, the intent of both Houses that the funds authorized under this legislation be used only to support preventive family planning services, population research, infertility services, and other related medical, informational, and educational activities. The conferees have adopted the language contained in section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. The legislation does not and is not intended to interfere with or limit programs conducted in accordance with State or local laws and regulations which are supported by funds other than those authorized under this legislation."[1] (Emphasis added.)

In addition, Congressman John D. Dingell made the following statement on the floor of the House:

> "Mr. Speaker, I support the legislation before this body. I set forth in my extended remarks the reasons why I offered the amendment which prohibited abortion as a method of family planning . . . .
>
> With the 'prohibition of abortion' the committee members clearly intended that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this Act."[2] (Emphasis added.)

Thus, it is apparent that the Congressional intent was to prohibit a broader scope of activity than a literal reading of section 1008 would require. In this light, our responses are as follows:

1. May a grant under Title X of the PHS Act be made to an organization which in addition to the

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[1] Conference Report No. 91-1667, Dec. 3, 1970, at pg. 8-9.

[2] Cong. Rec., Nov. 16, 1970, p. H. 10286 (daily edition).

provision of preventive family planning services, also provides, without Federal support, as part of its activities, abortion services as a method of family planning?

We do not believe that the word "program," as used in section 1008, was intended to be so comprehensive as to include any and all family planning activities carried on by an applicant for Title X funds. For example, we do not believe that a hospital offering abortions for family planning purposes, consonant with state law, would be disqualified from receiving Title X funds for the operation of a separate family planning program which utilized only preventive family planning methods. While the term "program" is not defined in the Act, the above quoted language of the Conference Report, stating that section 1008 was not "intended to interfere with or limit programs conducted in accordance with State or local laws" supported by other than Title X funds, is consistent with the view we have taken. It is recognized that in some situations, the abortion element in a program of family planning services may bulk so large and be so intimately related to all aspects of the program as to make it difficult, if not impossible to separate the eligible and non-eligible items of cost. In such a case, we think a grant for the project would be legally questionable.

2. May grants under Title X of the PHS Act be made to support research into fertility control methods which may prove to work in the manner of abortifacients?

As we understand the facts giving rise to this question, there are a number of substances which are under investigation for purposes of developing a means to control fertility. At present, the mode of action of

these substances is not entirely understood. After research it may be established that some of these substances act in the mode of an abortifacient. Your question is, in effect, whether faced with such a possibility, you may nevertheless undertake such fertility research.

We do not think that the statute or legislative history prohibits such research. In fact, the legislative history is replete with references to the need for research into methods of fertility control[3] including the " . . . screening and synthesis of new antifertility compounds."[4] To hold that such research could not be performed merely because of the possibility that there may be an abortifacient reaction would seem to run contrary to that expression of intention.

3. May grants under Title X of the PHS Act be made for the collection of data relating to the subject of abortion, for example a study of its effectiveness as a method of family planning?

As we have already indicated, inasmuch as the collection of data does not itself involve the provision of abortions, section 1008 would not, from a literal reading appear applicable.

While the collection of the data would thus appear legally supportable, the use of the data to promote or encourage abortions, even if such use is supported by non-Federal funds, may raise policy questions as to the data collection project. Representative Dingell's

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[3] House Report No. 91-1472, Sept. 26, 1970, at pg. 10.

[4] Senate Report No. 91-1004, July 7, 1970, at pg. 11.

statement, quoted earlier, indicates that is was the intention of section 1008 to assure that "abortion is not to be encouraged or promoted in any way." Thus, the collection of data or the provision of information which may be used for such purpose, while not legally prohibited, may however be considered as inconsistent with this "non-encouragement" policy.

National Center for Family Planning Services, Health Services and Mental Health Administration, Department of Health, Education, and Welfare, *A Five-Year Plan for the Delivery of Family Planning Services* (Oct. 1971)

* * * *

In addition to specific contraceptive services, programs should make available other related medical examinations and tests to assist in the early detection of illness and disease. While the program cannot provide full medical care because of its specialized nature, services should be provided for the screening and referral, including followup, of the patient to appropriate physicians, hospitals or other programs for necessary treatment. This mechanism is vital, given the fact that family planning is often the point of entry into a fragmented health care system for many individuals.

Effective interrelationships with the total health care system for the benefit of the patient also requires that the project provide orientation in family planning to the personnel of other health and social service programs which are, or may become sources of referral, such as hospital emergency rooms, outpatient clinics, drug rehabilitation programs, VD clinics, abortion clinics, and welfare programs.

* * * *

There is no Federal policy concerning abortion, although many states have moved recently to liberalize their abortion laws. The concern of the Department of Health, Education, and Welfare is that "whatever changes in the laws are effected, they must insure two

principles: 1) safety of the patient, and 2) elimination of social and economic discrimination."* The use of funds authorized under the Family Planning Services and Population Research Act of 1970 to pay for abortion as a method of family planning is prohibited. Within the context of family planning service programs, abortions are not viewed as a method of fertility control, but as a service that should be available in accordance with local laws only in the event of a human or contraceptive method failure.

As an indication of the extent to which many people are not presently able to adequately control their fertility through contraceptive means, it has been estimated that in 1967 there were over 800,000 induced abortions in the United States.** As the best possible methods of fertility control are made more accessible and more widely used, the incidence of abortion should decrease. Abortion would then serve as a backup measure for contraceptive failure, thereby still further assuring the freedom of choice of those who do not desire an unwanted birth.

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* J. Veneman, Letter to Senator Robert Packwood (R-Oregon), May 18, 1970.

** J. Abernathy, B. Greenberg and D. Horowitz, "Estimates of Induced Abortions in Urban North Carolina, Demography, 7:1, February 1970.

Memorandum from Joel M. Mangel, Deputy Assistant General Counsel, to Louis M. Hellman, M.D., Deputy Assistant Secretary for Population Affairs (Jan. 18, 1973)

OFFICE OF THE GENERAL COUNSEL

January 18, 1973

Louis M. Hellman, M.D.
Deputy Assistant Secretary for
Population Affairs

Joel M. Mangel
Deputy Assistant General Counsel
for Public Health

Family Planning--Section 1008, PHS Act--Prohibition of Abortion--Distribution of Film Version of the Report of the Commission on Population Growth and the American Future

You have asked our opinion as to whether funds appropriated for use under section 1005 of the Public Health Service Act may be used to distribute the film referred to above, in light of the prohibition in section 1008 of the Act against using any funds appropriated under Title X "in programs where abortion is a method of family planning."[1] At the outset, we would like to point out that this memorandum deals only with the film in question and does not purport to pass on the question of whether distribution of the report in its entirety would violate section 1008.

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[1] Section 1008, Public Health Service Act.

There is no question that section 1005[2] provides ample authority for the award of grants or contracts designed to disseminate family planning and population growth information. Furthermore, we believe that the film version of the Commission's report qualifies as informational material appropriate for distribution under that section.

Your concern arises out of the fact that among the many things discussed in the film is the issue of abortion, in the course of which various views on abortion are presented, and that on page 37 of the film script there appears the following statement:

> "After considerable deliberation, the majority of the Commission decided that abortion should not be a crime in any state where performed within a specified time period and under medically safe conditions."

For the reasons discussed below, we do not believe that section 1008 prohibits the distribution of the film in question by the inclusion of the above discussed segment on abortion.

As we have previously advised you, the scope of the section 1008 prohibition is somewhat ambiguous.

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[2] Section 1005 authorizes the Secretary "to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials)."

In our memorandum of April 20, 1971,[3] we advised that:

> "read literally the phrase 'programs where abortion is a method of family planning,' most reasonably limits the prohibition contained in section 1008 to the financial support of programs in which abortions are provided as a method of family planning."

On the other hand, we pointed out that Congressman Dingell, in explaining his purpose for proposing the amendment, stated:

> "With the 'prohibition of abortion' the committee members clearly intended that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this Act."[4]

Nevertheless, with regard to the collection of data relating to abortion, we went on to say that:

> "While the collection of the data would ... appear legally supportable, the use of the data to promote or encourage abortions, even if such use is supported by non-Federal funds, may

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[3] Memo, GH (Mangel to DASPA (Hellman), "Abortion as a Method of Family Planning--Section 1008 of the Public Health Service Act," 4/20/71, DF #38B.

[4] Id. at 3, quoting from Cong. Rec., Nov. 16, 1970, p. H.10286 (daily edition).

raise policy questions as to the data collection project." (Emphasis added.)[5]

While the Dingell statement introduces an additional element into the consideration of the section 1008 prohibition (i.e., "nonencouragement"), we continue to believe that it does not legally require the extension of the section 1008 prohibition beyond the literal impact of that section to the collection and dissemination of information.

However, even if we were to assume, arguendo, that the section 1008 prohibition extended to informational programs, we do not believe that it would prohibit distribution of the film.

Section 1008 prohibits the expenditure of Title X funds in programs in which abortion is a method of family planning. Even Congressman Dingell's statement, fairly read, addresses the abortion issue within the context of family planning.[6] Furthermore, the authority of the Secretary to expend funds in the field of abortion (other than as a method of family planning) is specifically recognized in the Conference Report accompanying the FY 1972 Appropriation Act, in which it is stated:

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[5] Id. at 2.

[6] In introducing his remarks, Congressman Dingell said: "I set forth in my extended remarks the reasons why I offered the amendment which prohibited abortion as a method of family planning ..." (emphasis added). Cong. Rec., Nov. 16, 1970, p. H10286 (daily edition). But cf. Conference Report, No. 91-1667, Dec. 3, 1970, at pp. 8-9.

"The Committee of Conference is agreed that in the population research, the prohibition in Title X of abortion as a method of family planning should not be construed so as to prevent scientific research into the causes of abortion and its effects."[7]

Thus, the purpose[8] of the Commission in making its recommendation is important not only to determine whether it is an "encouragement" of abortion but also whether it is an "encouragement" to use abortion as "a method of family planning."

Although the film does contain the above quoted recommendation, that State criminal penalties for abortion under the stated circumstances be repealed, the recommendation is followed by a clear statement that resort to abortion reflects a failure on the part of the family planning systems in the United States.[9] In fact, it is stated by the narrator of the film that:

"The Commission in making its recommendation that abortion laws be liberalized along the lines

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[7] H.R. Rep. No. 92-461, 92d Cong., 1st Sess. 8 (1971).

[8] Memo, GH (Goodman) to DASPA (Hellman), "Expenditure of Title X Funds for Research Dealing with Abortion--Effect of Section 1008, Public Health Service Act," 10/5/72, DF #38B. In that memorandum, we concluded that the purpose of the research, not the possible use to which some people might put the results, is the determining factor.

[9] "However, resort to abortion reflects a failure, because it means that the woman and man involved were not educated to birth control methods, or that they were legally or economically prohibited from obtaining birth control services." Film script, pp. 37-38.

> of the 1971 New York State Law, said that it was in no way advocating abortion as a substitute for family planning (emphasis added).[10]

Thus, the film specifically states that the Commission does not advocate abortion as a method of family planning, but recognizes it as a symbol of the failure of family planning. A close reading of the film script indicates that the Commission addressed the abortion issue in terms of legal prohibitions because it considered it to be a matter of personal rights and population control, but that it did not promote abortion as a means which government should support as a method of family planning.[11]

But even if the Commission's recommendation be taken as one which "encourages or promotes" abortion,[12] it clearly does not encourage abortion as a method of family planning.

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[10] Id. at 42.

[11] Id. at 37-44.

[12] While the Commission's purpose is stated in terms of "social [illegible]" and "woman's freedom of choice," it is arguable that [illegible] "encourage of promote" abortion.

United States Department of Health, Education, and Welfare, *Program Guidelines For Project Grants For Family Planning Services* (Jan. 1976)

INTRODUCTION

* * * *

Medical services in relation to family planning comprise the various aspects of health care given when a patient seeks advice or treatment for the control of reproduction. Such medical services should be part of a comprehensive medical care plan where patients served by a family planning project may receive education, advice, and referral for the screening, detection, prevention, or treatment of a variety of conditions with the objective of achieving and maintaining a state of good health, particularly with regard to reproduction. All patients desiring family planning advice or techniques should be given information, methods, or medication consistent with sound medical judgement and compatible with the personal convictions of the patient. Medical services must be administered in conformity with State and Federal statutes pertaining to medical practice. Delivery of medical services at family planning facilities will be the responsibility of physicians who have the training and/or experience to perform the required services.

* * * *

(d) Medical services related to family planning must include physician's consultation, examination, prescription, and continuing supervision; laboratory examination; contraceptive supplies; and necessary referral to other medical facilities when medically

indicated. Applicants and grantees are advised to familiarize themselves with the regulations governing sterilization, 42 CFR, Part 50, Subpart B, which are applicable to programs or projects supported in whole or in part with Federal funds. (See Appendix C.)

(e) Provision for social services related to family planning, including counseling, referral to and from other social and medical services agencies, and such ancillary services as are necessary to facilitate clinic attendance.

(f) Provision for the effective usage of contraceptive devices and practices.

(g) Provision for use of a broad range of medically approved methods of family planning including natural family planning methods.

(h) Provision for diagnostic and treatment services for infertility.

(i) Provision for coordination and use of referral arrangements with other providers of health care services, with local health and welfare departments, hospitals, and voluntary agencies, and health services projects supported by other Federal programs.

(j) Provision for informational and educational programs designed to achieve community understanding of the objectives of the program, to inform the community of the availability of services, and to promote continuing participation in the project by persons to whom family planning services may be beneficial.

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Patients who are pregnant and have received DES should be warned of the potential hazard (including vaginal adenosis and vaginal cancer) to any female offspring, and advised of the option of pregnancy termination.

• • • •

The IUD is a relatively safe and effective means of contraception. Questions have come up, however, about the safety of the IUD for women who become pregnant with the device in place. Patients should be advised as follows:

(1) If the menstrual period is late, or if pregnancy is suspected, the patient should be checked by her physician.

(2) If pregnancy is proven, the IUD should be removed if this can be done easily. Removal of the IUD early in pregnancy prevents serious complications from occurring and reduces the possibility of miscarriage.

(3) If the IUD is not removed, the patient should know there is an increased risk of infected abortion occurring when pregnancy is allowed to continue. The patient and her physician should discuss whether it is best to terminate or to continue the pregnancy.

(4) If a pregnancy is allowed to continue, whether or not the IUD is removed, the patient should be followed very closely by the physician for early signs of complications.

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POST-EXAMINATION INTERVIEW (EXIT INTERVIEW)

Following the physical examination and the selection of a family planning method, the patient should have an interview with an appropriately trained member of the health team for an interpretation of the clinical findings. The interviewer should be able to answer the patient's questions competently, courteously, and quickly, and give the patient understandable information. The following should be covered during the interview:

• • • •

(h) Give pregnancy counseling, when appropriate.

• • • •

(j) Make appropriate referrals for any needed services not furnished through the facility. (Such referrals should be followed-up by the project.)

• • • •

RETURN VISIT SERVICES AND FOLLOW-UP

• • • •

(a) • • •

(2) • • •

f. Advise patient that if she becomes pregnant with the IUD in place, there is risk of septic abortion. In such cases, if the IUD string is visible and the IUD can easily be removed, this should be done, and arrange-

ments for follow-up and/or referral should be made immediately. If the IUD cannot be removed, the patient should be advised of the option of pregnancy termination. Whatever the decision regarding the pregnancy, she must have close medical supervision.

• • • •

Memorandum from Office of the General Counsel, Department of Health, Education, and Welfare (April 14, 1978) (Attachment B to *Amicus* Brief of the Secretary of Health and Human Services, *Valley Family Planning v. North Dakota*, 661 F.2d 99 (8th Cir. 1981) (No. 80-1471))

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE
OFFICE OF THE GENERAL COUNSEL

Elsie Sullivan, Assistant for
Information and Education
Office for Family Planning, BCHS
Senior Attorney
Public Health Division

Section 1008, PHS Act--Permissible Activities by Grantees.

You have orally requested our views as to what abortion-related activities a grantee of funds under Title X of the Public Health Service Act may conduct, in light of the prohibition of § 1008 of the Act:

> "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

Specifically, you question whether a Title X grantee may, consistent with § 1008, do the following:

1. Supply information to those who do not want to continue their pregnancies, and may be interested in obtaining abortions.

2. Refer clients to doctors to obtain abortions.

3. Inspect abortion facilities to see if they meet national Planned Parenthood guidelines.

4. Provide speakers to debate in opposition to "Right to Life", anti-abortion speakers.

5. Advocate the need and suitability of abortion in the community.

6. Produce and/or show movies that tend to encourage and promote a favorable attitude toward abortion.

7. Provide abortion as a suitable back-up method of family planning.

8. Bring legal action to liberalize statutes relating to abortion and state it "would refer clients to physicians for abortions and would offer services to assist clients in procuring abortions ..."

9. Bring pressure on a local Board of Supervisors to change its relatively restrictive abortion policy at the county hospital.

10. Counsel women, especially, those not 18 years of age, to cry "rape" to obtain abortions at the county hospital.

11. Be a dues paying participant in a national federation whose five year plan relative to family planning includes as its purpose to provide leadership in (among other things) abortion, whose stated objective is the

"reaffirming and protecting the legitimacy of induced abortion as a necessary back-up to contraceptive failure, and extending safe, dignified services to women who seek them; whose basic service program elements include "Abortion Services (or local referral)".

This office has traditionally taken the view that § 1008 not only prohibits the provision by Title X grantees of abortion as a method of family planning as part of the Title X-supported program, but also prohibits activities which promote or encourage the use of abortion as a method of family planning by the Title X-supported program.[1] Under this view, the provision of information concerning abortion services, mere referral of an individual to another provider of services for an abortion,[2] and the collection of statistical data and information regarding abortion[3] are not considered to be proscribed by § 1008. The provision of "pregnancy counselling" in the sense of encouraging persons to obtain abortions[4]

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[1] GH (Mangel to DASPA (Hellman), "Abortion as a Method of Family Planning--Section 1008 of the Public Health Service Act" (4/20/71).

[2] GH (Conrad) to DASPA (Hellman), "Contract for Research on Natural Family Planning--Provision of Abortion" (11/5/77).

[3] GH (Mangel) to DASPA (Hellman), "Family Planning--Section 1008, PHS Act--Prohibition of Abortion--Distribution of the Film Version of the Report of the Commission on Population Growth and the American Future" (1/18/73); GH (Goodman) to DASPA (Hellman), "Expenditures of Title X Funds for Scientific Research Dealing with Abortion--Effect of Section 1008, Public Health Service Act" (10/5/72).

[4] GH (Mangel) to RAX (Young), "Interpretation of Section 1008 of the Public Health Service Act, et al." (5/31/73).

and the provision of transportation to persons to enable them to obtain abortions, on the other hand, are considered to be proscribed by § 1008.[5] The test to be applied, then, appears to be whether the immediate effect of the activity in question is to encourage or promote the use of abortion as a method of family planning. If the immediate effect of the activity is essentially neutral as in the cases of mere referral or collection of statistical date,[6] then the activity does not fall afoul of § 1008. If the immediate effect of the activity is to encourage or assist in procuring an abortion as in the case of "pregnancy counselling" or providing transportation to obtain an abortion,[7] on the other hand, it falls afoul of § 1008. Applying this test to the activities described in the first paragraph, we draw the following conclusions:

1. Items 1 and 2[8] above may, as discussed in the preceding paragraph, be conducted by the Title X-supported program. See opinion cited at footnote 2.

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[5] GH (Mangel) to OFO (Landerbaugh), "Review of Correspondence from Region IX Involving OEO transferred Grant" (4/10/73).

[6] For example, the compilation of statistical data can be used by both proponents and opponents of abortion; in a mere referral, the person making the referral does not present the medical or other arguments for or against obtaining an abortion.

[7] Clearly, the provision of "pregnancy counselling" and transportation services promote the immediate use of abortion as a method of family planning.

[8] We read item 2 as meaning "mere referral," that is, the provision to a patient of the name, address and/or telephone number of a provider of services, without further affirmative action to secure the services of that provider.

2. Items 4 through 10 above all clearly involve various forms of advocacy of abortion as a method of family planning, and cannot be conducted as part of the Title X-supported program.

3. The effect of item 3 above is unclear. While it could be argued that there is no purpose to a facility inspection except as a basis for subsequently encouraging persons to use it, we do not think this is necessarily so. For example, a grantee may routinely inspect provider facilities to which it may make referrals to determine their suitability for the provision of services. The inspection itself clearly has no effect; it is the actions subsequently taken as a result of the inspection that may promote or encourage abortion. We are inclined to view item 3 as analogous to the collection of abortion data and information and thus not falling afoul of §1008, assuming of course that the grantee does not subsequently use the information gained as a result of the inspection to "encourage" abortions.

4. With regard to item 11 above, we think that membership in the national organization does not necessarily imply sufficient commitment to the abortion-related goals and activities of the national organization to be proscribed by §1008, as long as there are other legitimate program-related reasons for the affiliation (such as access to data or information useful to the Title X-supported program).

The thrust of your questions illustrates the importance of

a point we have made in the past but which, in the case of the grantee or grantees in question here, may have been overlooked. Specifically, where a Title X grantee also conducts other activities which are not part of the grant-supported program and would not be permissible under the statute if they were part of the program, the grantee must ensure that the Title X-support program is separate and distinguishable from those other activities. Separate bookkeeping entries are not enough.[9] As we have previously observed:

> "... in some situations, the abortion element in a program of family planning services may bulk so large and be so intimately related to all aspects of the program as to make it difficult, if not impossible to separate the eligible and noneligible items of cost. In such a case, we think a grant for the project would be legally questionable."[10]

Accordingly, we suggest that the grant or grants giving rise to your questions be carefully reviewed to make sure that any abortion-related activities the grantees may be conducting are separate and distinct from the Title X-supported program.

Carol C. Conrad

cc: Mr. Beattie, OGC
Ms. Martin, OPA
Dr. Martin, BCHS

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[9] Op. cit., memorandum of 4/10/73.

[10] Op. cit., memorandum of 4/20/71.

Memorandum From Department of Health, Education, and Welfare (July 25, 1979) (Attachment A to *Amicus* Brief of the Secretary of Health and Human Services, *Valley Family Planning v. North Dakota*, 661 F.2d 99 (8th Cir. 1981) (No. 80-1471))

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Elsie Sullivan
Staff Assistant
Office for Family Planning
Bureau of Community Health Services

Senior Attorney
Public Health Division

§ 1008, PHS Act - 42 CFR 59.5(d) - Abortion Referrals - DF 38B

You have orally requested our view as to whether a grantee under Title X of the Public Health Service Act is required to refer persons to other health care providers who might provide abortions.[1] In our view a grantee is not required by the statute or regulations to make such referrals, except in the limited circumstances discussed below.

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[1] As we understand the question, the project would be involved in these abortion decisions only to the extent of providing the patient with information about the existence of a provider who might provide an abortion. In any such referral, the provider to whom the patient is referred will, of course, be exercising his or her own professional judgment as to the advisability of performing an abortion.

Your question arises out of a section of the Title X regulations, 42 CFR 59.5, which provides in pertinent part as follows:

> "An approvable project must contain each of the following unless the Secretary determines that the applicant has established good cause for its omission:
>
> * * * * *
>
> (d) Provision for medical services related to family planning including ... necessary referral to other medical facilities when medically indicated."

Also relevant to your question are § 1008 of the Act, and § 401(b) of Pub. L. 93-45, the so-called "conscience clause." (Those statutory provisions are set out below.) Your question, therefore, has three aspects: (1) Does § 59.5(d) by its terms require referrals to providers who might recommend or provide abortions? (2) Would requiring the making of such referrals fall afoul of § 1008? (3) Would requiring the making of such referrals fall afoul of the "conscience clause"? Our views follow.

Scope of § 59.5(d)

By its terms, the only referrals which are required under § 59.5(d) are those which are "necessary" because they are "medically indicated." Under this language, the test becomes one of medical judgment as to whether medical care not available from the project is indicated. Thus, there is clearly no requirement that a project make an "abortion referral" (i.e., make a referral specifically to have an abortion performed), since in the final analysis that decision rests with the patient and the person or entity to whom the patient is referred. Moreover, there

is clearly no requirement that referral be made in a case in which, in the judgment of the project's professional staff, a referral to other sources is not medically indicated. Just as clearly, however, § 59.5(d) requires referral to a provider who might recommend or provide an abortion in cases where such a referral is necessary because of the patient's medical condition or the condition of the fetus. For example, cases where continuance of the pregnancy would endanger the mother's life would fall in the latter category. Hence, while § 59.5(d) does not require a project to make referrals to abortion providers in all cases, a project could not - consistent with § 59.5(d) - refuse as a matter of policy to make such referrals in any case, regardless of the medical indications therefor.

§ 1008 PHS Act

Having concluded that § 59.5(d) requires referrals to providers who might provide abortions in some (but not all) cases (i.e., where such referrals are deemed necessary by project medical staff because of medical indications), the question becomes does this requirement conflict with § 1008? We think it does not. Section 1008 prohibits the use of Title X funds "in programs where abortion is a method of family planning." As we have previously advised,[2] a project may, consistent with § 1008, make "mere referrals" for abortion, as long as it does not then go on to promote or encourage use of the procedure for family planning purposes. We see no

[2] Memorandum, GH (Conrad) to DASPA (Hellman), "Contract for Research on Natural Family Planning - Provision of Abortion" (11/5/75); Memorandum GH (Conrad) to DF # 38B, "Revised Draft of Response to Mears' Letter Telephoned to Dr. Hellman's Office" (7/29/75).

reason why requiring the making of such referrals under the limited circumstances described above should change this result. Indeed, we think that where such a referral is necessary because of medical indications, abortion is not being considered as a method of family planning at all, but rather as a medical treatment possibly required by the patient's condition. As such, it would not come within the scope of § 1008 at all, since that section reaches only cases which relate to the use of abortion "as a method of family planning."

"Conscience Clause"

Section 401(b) of Pub. L. 93-45 provides, as pertinent here, as follows:

> "(b) The receipt of any grant ... under the Public Health Service Act ... by any entity does not authorize any ... public official ... to require -
>
> * * * * *
>
> (2) such entity to -
>
> (A) make its facilities available for the performance of such ... abortion if the performance of such ... abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or
>
> (B) provide any personnel for ... assistance in the performance of any ... abortion if the ... assistance in the performance of such ... abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel."

With respect to the "conscience clause", the question becomes whether requiring referrals under the limited circumstances described above contravenes this provision. By its terms § 401(b)(2) establishes only two limitations on the Secretary's authority to regulate grantee activities: (1) he cannot require a grantee to make its facilities available for the performance of abortions, and (2) he cannot require a grantee to require its personnel to perform or assist in the performance of abortions if doing so conflicts with the beliefs of those individuals. For the reasons given below, we do not believe that the referrals described above come within the prohibition of either § 401(b)(2)(A) or § 401(b)(2)(B).

It is clear that requiring a grantee to make referrals to providers of abortions does not fall afoul of the first limitation (§ 401(b)(2)(A)), since that subsection only covers the "performance of an abortion" by assisted facilities. The term "performance of an abortion" would not ordinarily be read as encompassing mere referrals, but would ordinarily mean performance of the operation itself. There is nothing in the legislative history to suggest that the term "performance" should be given other than its natural scope.

Thus, if the requirement of § 59.5(d) falls afoul of anything, it can only be the second limitation, § 401(b)(2)(B). However, we do not believe that requiring referrals where abortion appears medically indicated falls afoul of this limitation either. First, requiring referrals to providers who may provide abortions is at most requiring "assistance in the performance of an abortion" within the meaning of the statute. However, the legislative history suggests on balance that the type of "assistance" envisioned was that which would be provided by support personnel in the course of the operation itself

-- e.g., nursing. See, for example, the remarks of Sen. Long in a colloquy with Sen. Church, the sponsor of the Senate bill:

> "Mr. Long. If I understand what the Senator is saying, he is saying that a nurse or an attendant who has religious feelings contrary to ... abortion should ... and would not be required ... to participate in any such procedure ....
>
> "Mr. Church. That is correct." 119 Cong. Rec. 9597 (3/27/78).

Second, § 401(b)(2)(B) only restricts the Secretary from requiring grantees to require their employees to act contrary to the beliefs those employees hold as individuals; it does not restrict the Secretary from requiring grantees to act contrary to the beliefs the grantees hold as institutions. This difference becomes quite clear when subparagraphs (A) and (B) are read together: subparagraph (A) relates to *institutional* beliefs, while subparagraph (B) refers only to the beliefs of the institution's personnel. Under standard rules of statutory construction, since Congress explicitly covered institutional beliefs in subparagraph (A) and omitted covering them in subparagraph (B), it must be assumed to have intended not to cover them in the latter subparagraph.[3] Thus, if a grantee is staffed by personnel whose

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[3] Sutherland, Statutory Construction, (Sands, 4th ed.) § 47.23.

This interpretation is supported by the rejection of the Senate language, which would have made no distinction between the requirements applying to institutions and those applying to individuals:

(continued...)

beliefs do not permit them to make referrals under the above circumstances, the grantee may be required under § 59.5(d) to hire persons whose beliefs will not preclude them from making such referrals, and such a requirement does not conflict with § 401(b)(2).

If you have any questions on the above, please do not hesitate to contact us.

Carol C. Conrad

Prepared by: CConrad:lsm: 7/16/79: Y2006: 4A-53

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[3] (...continued)

"... there shall not be imposed, applied, or enforced ... any requirement ... which would result in ... causing ... any physician, or health care personnel, or any hospital or other health care institution to ... assist in the performance of, any abortion ... if the performance of such abortion ... would be contrary to the religious beliefs of such physician or other health care personnel, or the person or group sponsoring or administering such hospital or other institution." 119 Cong. Rec. 9595 (3/27/73).

See Sutherland, supra, at § 48.18.

The discussion on the floor of the House of the House language ultimately adopted as § 401(b) is ambiguous, but contains support for this reading of the statute. For example, Rep. Loland, a co-sponsor of the House language, summarized its provisions as follows:

> "This section 401 provides that receipt of financial assistance ... does not constitute a ... basis for (an) ... administrative order requiring an individual to aid in performing (an) ... abortion ....
>
> "Nor does receipt of financial assistance provide legal authority for (an) ... administrative order requiring the provision of personnel or facilities by any entity for the performance of ... abortion ...". 119 Cong. Rec. 17454 (5/31/73) (Emphasis added).

United States Department of Health, Education, and Welfare, *Program Guidelines For Project Grants For Family Planning Services* (1981)

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8.3 HISTORY, PHYSICAL ASSESSMENT, AND LABORATORY TESTING

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- Physical Assessment

Female clients requesting prescriptive methods of contraception (e.g., oral contraceptives, IUDs, diaphragms) must have a general physical examination at the initial medical visit. The initial examination should include at least the following:

> *--Height; weight; blood pressure; thyroid; hear; lungs; extremities; breasts, including instruction in self-exam; abdomen; pelvic examination, including visualization of the cervix and bimanual exam; rectal exam, as indicated.*

For oral contraceptive users, initial and annual physical examinations must include evaluation of weight, blood pressure, extremities, breasts, and pelvic organs. For IUD users, initial and annual physical exam, blood pressure, and pelvic exam are required, and a more complete exam is recommended.

Female clients using nonprescriptive methods or diaphragms should have a general physical examination at least every two years. This exam is particularly important for clients

who are not receiving general health care elsewhere.

* * * *

9.0 Recommended Services

Since the services contained in this section are important to reproductive health care, it is recommended that they be provided at individual service sites.

9.1 GONORRHEA SCREENING

In community or client populations with a high incidence of gonorrhea, endocervical cultures for gonorrhea should be performed on each female client at the time of the initial pelvic examination and repeated as indicated. A yield of equal to or greater than 4 percent positive cultures merits universal screening

For additional guidance, see Appendices -- Sexually Transmitted Diseases.

9.2 MINOR GYNECOLOGIC PROBLEMS

Family planning programs should provide for the diagnosis and treatment of minor gynecologic problems so as to avoid fragmentation or lack of medical care for clients with these conditions. Problems such a vaginitis or urinary tract infection may be amenable to on-the-spot diagnosis and treatment, following microscopic examination of vaginal secretions or urine.

9.3 GENETIC SCREENING AND REFERRAL

For clients at risk for transmission of genetic abnormalities, some basic effort to define this risk is a logical component of family pla ing services. Initial genetic screening and referral services should be offered to clients who are in need of such services.

Initial screening consists of a careful family history of the client and the client's partner. More complete genetic screening and counseling may be offered *directly* (by a genetic counselor who functions in association with a clinical genetic team capable of providing comprehensive services for a broad range of genetic disorders) or *indirectly* (through referral to a comprehensive genetic service program or programs which may be federally, State, or privately funded). In either case, linkages with a comprehensive genetic service program should be established, specifically with clinical genetic services centers.

Where feasible, in-service training in genetics should be arranged for project staff to enable them to provide simple genetic screening. Training may be appropriately provided by a genetic service program to which the project is linked. The purpose of training is to familiarize staff with the indications for genetic services, referral mechanisms, and resources. Literature and informational materials regarding the availability of genetic services, including but not limited to prenatal diagnosis, should be available in the appropriate langauge to all clients on request.

When genetic screening services are

offered by a project, they must (1) be supported by a program of public information and education which is sensitive to the concerns of local ethnic and religious groups and upholds the dignity of individual s with congenital physical or mental limitations, (2) include education and counseling to all clients on a voluntary basis, and (3) include referral for testing or further screening if indicated.

For additional guidance, see Appendices -- Genetic Screening.

9.4 HEALTH PROMOTION/DISEASE PREVENTION

For many clients, family planning programs are their only continuing source of health information and medical care. Therefore, while most of the client services will necessarily relate to fertility regulation, family planning programs should, whenever possible, provide health maintenance services such as screening, immunization, and general health education and counseling directed toward health promotion and disease prevention. These additional services should promote the clients' general state of health and, in turn, the health of their infants and children. Programs are therefore encouraged to assess the health problems prevalent among the populations they serve and to develop services to address them.

Nutrition services are an example of an important activity directed toward promoting health and preventing disease which can be integrated into the existing family planning services. Projects should provide nutritional

problem identification, basic nutrition information, screening, and medical care to clients at high risk of nutrition problems or those requiring nutritional management of disease. These services can be provided without the resources of a full-time nutritionist. Project staff can deliver such services with nutrition training and consultation with a qualified nutritionist.

For further information, see Appendices -- Health Promotion/Disease Prevention

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Memorandum from Nabers Cabaniss, Deputy Assistant Secretary for Population Affairs, to Regional Health Adminstrators (Dec. 8, 1987) (Exhibit G to Complaint, *Rust v. Bowen*, 690 F. Supp. 1261 (S.D.N.Y. 1988) (No. 88-0702))

Date Dec. 8, 1987

From Nabers Cabaniss

Subject Office of Population Affairs Program Instruction Series OPA-87-4: AIDS Education, Counseling and Testing in Title X

To Regional Health Administrators
Regions I-X

Evidence suggests that an increasing number of women of childbearing age will become infected with Human Immunodeficiency Virus (HIV) either as a result of intravenous drug use or through heterosexual transmission of the virus. Title X provides family planning services to 4.3 million sexually active women annually. Most of these women are young (two-thirds below the age of 25), many are members of minority groups, and 85 percent are members of low income families. These characteristics of Title X clients closely resemble the characteristics of the population of women thought to be at high risk of HIV infection. Thus, Title X clinics represent appropriate settings to try to slow the spread of HIV infection.

All Title X clinics must offer, at a minimum, education on HIV infection and AIDS, counseling on risks and

infection prevention, and referral services. Other services such as risk assessment, counseling about testing and administering tests may also be provided. If other resources are unavailable, Title X funds may be used to support these services. Of particular importance is the role of Title X projects in offering effective methods of family planning to sexually active HIV-infected women who run a high risk of perinatal transmission in pregnancy and who run a significant risk of transmitting HIV to other sexual partners.

TERMS

The term HIV (Human Immunodeficiency Virus) refers to the virus which may infect persons and which causes AIDS.

The term AIDS (Acquired Immunodeficiency Syndrome) refers to the end-stage of HIV infection characterized by life-threatening or severely disabling diseases, e.g., serious infections, rare cancers, or neurological disorders.

In addition to AIDS, the spectrum of HIV infection includes an early stage without symptoms which may last several years and an intermediate symptomatic stage sometimes called ARC or AIDS-Related Complex. During all stages of HIV infection, the infected person can transmit the virus to others by sexual contact, contact with blood (including sharing of needles), or from mother to child during pregnancy or childbirth and perhaps by breast feeding.

In this program instruction, the term AIDS refers only to the end-stage of HIV infection; the term HIV infection will be used to refer to all other stages of the infection.

Counseling refers to the provision of information and education concerning HIV infection, its effects, high risk activities associated with it, and methods of prevention or risk reduction. Where testing is offered, counseling includes both pre and post test discussions with the client.

Risk Assessment refers to the process of identifying persons from among a larger client population who, because of their participation in high risk activities, symptoms, or expressed interest may be identified as high priority candidates for HIV testing.

Testing refers to administration and interpretation of both the ELISA and the Western Blot blood tests which indicate whether the client has antibodies to HIV and, therefore, (1) is infected with HIV, (2) can spread the infection to other persons, and (3) may eventually progress to AIDS.

STAFF TRAINING AND INFECTION CONTROL

Title X General Training and Nurse Practitioner Training programs have taken steps to increase their emphasis on training on HIV infection and AIDS. Clinic staff should be encouraged to participate in training provided by the Title X training program and other sources. Clinic staff should become familiar with the precautions contained in Recommendations for Prevention of HIV Transmission in Health Care Settings, issued by the Centers for Disease Control (CDC) on August 21, 1987. (copy enclosed)

Title X clinics are strongly encouraged to implement the practices recommended by CDC.

PREGNANCY

A woman who has tested positive for any infection should be carefully counseled on the risks pregnancy poses for her as well as for her baby. She should be offered effective methods to prevent both pregnancy and disease transmission as discussed above. For HIV-infected women choosing temporary methods of contraception, clinics should emphasize follow-up to insure continued access to and utilization of contraceptive services.

A client who participates in high risk activities should be told that, even if she has used condoms during sexual intercourse, she should stop all high risk activity and be tested for HIV infection before attempting to become pregnant. Testing should be delayed until at least 3 months after stopping all high risk activity to provide time for antibody formation necessary to insure validity of the test.

If already pregnant, a woman infected with HIV should be referred for appropriate medical care for herself and her infant. She should be provided counseling about the significant risks of perinatal transmission as well as transmission of the virus to her sexual partner(s).

American College of Obstetricians and Gynecologists, Statement of Policy, *Further Ethical Considerations In Induced Abortion* (1977)

* * * *

Pregnancies often involve medical, social and economic factors which impact adversely on the health of the woman; and while induced abortions may be one option in the management of such pregnancies, other alternatives may, in fact, be equally or even more appropriate in solving these problems. In order to preserve the values to which this document has referred, the following measures are recommended to ensure the availability of proper medical care and should apply to the needs of all women regardless of age or marital status:

* * * *

4. Provision of adequate and supportive counseling presenting the practical alternatives for the management of problem pregnancies. Counseling directed solely toward either promoting or preventing abortion does not sufficiently reflect the full nature of the problem or the range of options to which the patient is entitled. Appropriately balanced counseling, combined with the available and accessible facilities, provides the minimum base for the opportunity to make a truly informed choice.

* * * *

American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* (6th ed. 1985)

* * * *

FAMILY PLANNING

The physician should make available to patients information on reproductive physiology, methods of fertility control, and sterilization. Family planning services should be offered within a context of comprehensive counseling, including human sexuality and the prevention of sexually transmitted infections. Where appropriate, family planning services should be integrated into regular gynecologic care to allow continued observation.

Another aspect of family planning is preconceptional counseling. This can help determine the advisability and timing of pregnancy, assess and possibly stabilize risks, and reinforce good health and lifestyle habits that are conducive to pregnancy. This type of counseling before conception can help promote the well-being of the fetus during the first several weeks of gestation when a woman may not be aware she is pregnant.

A general medical and gynecologic history, with physical examination and appropriate laboratory studies, should be used to evaluate the relative or absolute contraindications to specific family planning methods for a particular patient. It is important to establish the level of the patient's knowledge about reproductive physiology and about her specific needs. She should be made aware of the availability, effectiveness, and relative risks of different methods. Conception control is the responsibility of both partners; both male and female methods should be considered.

The sexually active adolescent girl deserves special

attention because of the high incidence of unintended pregnancy in this population. The gynecologist should attempt to ensure that she has access to the most suitable methods of contraception.

In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy. When possible, and with the patient's approval, the physician should offer this counseling to her partner and to her parents if she is a dependent adolescent, before these difficult decisions are made. If the patient elects abortion, she should be counseled for future reference that abortion is not recommended as a primary method of family planning. When pregnancy termination is recommended by the physician for medical or psychiatric indications, consultation may be appropriate.

* * * *

American Medical Association, *Current Opinions of the Council on Ethical and Judicial Affairs* (1986)

PREAMBLE:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of

other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

* * * *

3.04 REFERRAL OF PATIENTS. A physician may refer a patient for diagnostic or therapeutic services to another physician, limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever he believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless he is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements. (V, VI)

* * * *

8.07 INFORMED CONSENT. The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his

care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment. (I, II, III, IV, V)

* * * *

General Accounting Office, *Restrictions On Abortion And Lobbying Activities In Family Planning Programs Need Clarification* (Sept. 24, 1982)

REPORT BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Restrictions On Abortion And Lobbying Activities In Family Planning Programs Need Clarification

Some family planning grant recipients' practices raised questions as to whether they comply with restrictions on abortion-related activities, but there was no evidence that title X funds had been used to pay for abortions or to advise clients to have abortions. The Department of Health and Human Services (HHS) needs to set forth clear guidance on the scope of abortion restrictions in its title X program regulations and guidelines.

Even if this is done, title X recipients would still be allowed to carry out abortion activities--not with title X funds, but as a part of their overall activities by organizationally separating the title X family planning program. The Congress may want to clarify its intent if it does not want title x funds to go to organizations providing abortions.

Lobbying by recipients was generally not paid with title X program funds and therefore not subject to Federal lobbying restrictions. However, recipients incurred some expenses that raised questions as to adherence with Federal lobbying restrictions. HHS needs to make its guidance in this are more specific and consistent.

COMPTROLLER GENERAL
OF THE UNITED STATES
WASHINGTON, D.C. 20548

The Honorable Orrin G. Hatch
Chairman, Committee on Labor
and Human Resources
United States Senate

The Honorable Jeremiah Denton
Chairman, Subcommittee on Aging,
Family and Human Services
Committee on Labor and Human Resources
United States Senate

In accordance with your September 8, 1981, request we have reviewed the family planning program authorized by title X of the Public Health Service Act to determine whether title X funds have been used to finance lobbying activities or to support abortion-related activities.

Comments were obtained only from the Department of Health and Human Services and not from individual grant recipients included in our review. In accordance with our policy, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services; the Director, Office of Management and Budget; other interested congressional Committees and Subcommittees; the grant recipients included in the review; and other interested parties.

Charles A. Bowker /s/

Comptroller General of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

RESTRICTIONS ON ABORTION AND LOBBYING ACTIVITIES IN FAMILY PLANNING PROGRAMS NEED CLARIFICATION

DIGEST

Title X of the Public Health Service Act authorizes the Department of Health and Human Services (HHS) to make grants for a broad range of family planning services. Recipients of title X funds, however, are restricted from using program funds for abortions or certain abortion-related activities and for lobbying.

At the request of the Chairmen of the Senate Committee on Labor and Human Resources and the Senate Subcommittee on Aging, Family and Human Services, GAO reviewed the activities of selected title X grantees operating family planning clinics to determine whether title X funds were being used for such activities.

CLARIFICATION OF ABORTION RESTRICTIONS NEEDED

GAO found no evidence that title X funds had been used for abortions or to advise clients to have abortions. Since 1971, HHS has held that the restrictions of section 1008 prohibiting the use of title X funds "* * * in programs where abortion is a method of family planning" are applicable to only that part of a recipient's operation supported by title X. HHS' interpretation of section 1008 allows title X recipients to use non-title X funds to

carry out abortion-related activities which would not be allowed as part of the title X program, so long as the abortion activities are separated from the title X family planning services.

Thus, HHS' policy allows title X recipients to use organizational techniques to insulate the title X program from abortion activities prohibited by section 1008 and thereby not jeopardize their eligibility for title X funds. Because the distinction between the recipients' title X and other activities may not be easily recognized, the public can get the impression that Federal funds are being improperly used for abortion activities.

About 74 organizations receiving title X funds perform abortions at clinics colocated with family planning programs. Under HHS' policy, these agencies can organize family planning and abortion activities into separate programs and still comply with the HHS interpretation of section 1008.

Congressional guidance may be needed if the Congress does not want title X funds to go to organizations providing abortions.

FAMILY PLANNING CLINICS NEED FORMAL GUIDANCE ON ABORTION-RELATED MATTERS

HHS has traditionally held that section 1008 not only prohibits abortion as a method of family planning, but also prohibits activities which encourage, promote, or advocate abortion. These policies evolved from a series of HHS' legal opinions, but have never been set forth in regulations or guidelines--HHS' formal mechanisms through which policy is provided to grant recipients. In

addition, the legal opinions do not always reach clinics and sometimes "draw a fine line" between allowable and unallowable activities, thereby failing to provide clear guidance on abortion-related matters.

GAO reviewed the activities of 14 family planning clinics to determine whether title X funds were being used for abortion-related activities. Although only six clinics had received copies of the legal opinions, clinic staff who counsel title X clients generally said they were aware of HHS' abortion policy restrictions, and GAO found no indications that any women were advised or encouraged to have abortions. However, GAO found variations in clinic practices, some of which GAO believes are questionable in light of HHS' interpretation of section 1008. These include:

-- Counseling practices which do not present alternatives to abortion.

-- Abortion referral practices which may go beyond HHS' referral policy.

-- Using educational materials which present barrier methods of contraception with early abortion in case of failure as a method of family planning.

TITLE X RECIPIENTS NEED MORE SPECIFIC GUIDANCE ON LOBBYING

Using title X program funds for lobbying--attempting to influence legislation or appropriations pending before the Congress--is restricted by Federal appropriations laws, HHS' regulations and instructions, and the Office of Management and Budget's (OMB's) guidance. However, neither HHS nor OMB has specifically identified

activities that constitute lobbying. Also, Federal guidance setting forth restrictions on dues paid to organizations that lobby is inconsistent between public and other non-profit title X recipients.

All seven title X recipients reviewed for lobbying had incurred expenses that, in GAO's opinion, raised questions as to adherence with Federal restrictions. Two recipients lobbied, but GAO could not determine from their records whether program funds were used. Most lobbying expenditures of the other five recipients did not involve program funds and were therefore not subject to Federal restrictions. However, of these five

-- all used program funds to pay dues to organizations that lobby and

-- two used small amounts of program funds to lobby at the Federal and/or State level.

While Federal cost principles clearly prohibit public organizations from using program funds for dues to organizations that do substantial lobbying, the cost principles for other nonprofit organizations are silent on this restriction. Nonetheless, such expenditures could be questioned in light of the restriction in HHS' appropriation law that the funds cannot be used to pay the salaries or expenses of any grantee, contractor, or their agent to engage in any activity designed to influence legislation pending before the Congress.

Two recipients used small amounts of program funds to attend conferences during which lobbying took place and to correspond with members and/or staff of the Congress to advocate for or against pending legislation. One recipient displayed a poster at a title X clinic that urged

clients to write the Congress to defeat pending legislation banning abortion. While any use of program funds in this lobbying effort was indirect, HHS holds that title X recipients are not to advocate abortions or promote a favorable attitude toward abortion.

HHS has recognized the need to establish more specific guidance on lobbying and the payment of dues to lobbying organizations. In this regard, HHS has initiated action to amend the cost principles for grantee organizations.

RECOMMENDATIONS TO THE SECRETARY OF HHS

Pending revision of Federal cost principles, GAO recommends that the Secretary provide interim guidance to title X recipients on activities that constitute lobbying and are therefore unallowable as program expenditures.

GAO also recommends that the Secretary establish clear operational guidance by incorporating into the title X program regulations and guidelines. HHS' position on the scope of the abortion restriction in section 1008.

MATTERS FOR CONSIDERATION BY THE CONGRESS

Even if the abortion-related recommendation to the Secretary is implemented, title X recipients would still be allowed to carry out abortion activities--not with title X funds, but as a part of their overall activities by organizationally separating the family planning program from those activities.

Because of the sensitivity of the abortion issue and the

concern over how Federal family planning funds can be used, the Congress may want to provide guidance to HHS to clarify the intent of section 1008.

AGENCY COMMENTS

HHS agreed with GAO's recommendations. HHS plans to incorporate in its title X guidelines an explanation of its position on the implementation of section 1008 and to publish proposed regulations defining lobbying activities by title X and other grant recipients that are unallowable. GAO obtained comments only from HHS.

Contents
[of GAO Report]

ABBREVIATIONS

GAO	General Accounting Office
HHS	Department of Health and Human Services
OMB	Office of Management and Budget

CHAPTER 1

INTRODUCTION

In a September 8, 1981, letter, the Chairmen of the Senate Committee on Labor and Human Resources and the Senate Subcommittee on Aging, Family and Human Services requested that we review selected aspects of the title X family planning program concerning compliance with prohibitions in Federal statutes governing abortion-related activities and lobbying. (See app.I.) Our review focussed on the Department of Health and Human Services' (HHS') policies and practices for implementing and monitoring compliance with those Federal laws and the practices at selected title X recipients.

BACKGROUND

The Family Planning Services and Population Research Act of 1970 (Public Law 91-572) added title X to the Public Health Service Act. Project grants with public and private nonprofit organization, operating voluntary family planning projects and clinics, are the major component of the title X program.

The 1970 Act established within HHS' Public Health Service an Office of Population Affairs to be directed by a Deputy Assistant Secretary. The act intended that the Deputy Assistant Secretary would administer all of the HHS programs related to family planning and population research and coordinate all domestic and international family planning activities administered by the Federal Government. In practice, however, family planning programs are administered by HHS' component agencies and the Deputy Assistant Secretary coordinates efforts.

The Office for Family Planning within HHS' Bureau of Community Health Services has overall responsibility for the title X program. The Bureau sets policy, issues guidance, and allocates funds for services to HHS' regional offices, which are responsible for the day-to-day administration of the Federal title X family planning program.

HHS' regional offices directly fund some organizations which provide family planning services, but most title X funds are awarded to intermediate organizations which distribute grant funds to delegate agencies that operate clinics. The intermediate organizations are responsible for administering the grant and for overseeing the activities of their delegate agencies. For example, Genesee Region Family Planning Program, Inc., in New York is an intermediate organization which funds seven delegate agencies that operate several clinics. It is responsible to HHS for the overall grant administration and, in turn, holds its delegate agencies responsible for proper adminstration of their respective subgrants.

Since 1970 HHS has provided over $1 billion for project grants for family planning services under title X. In fiscal year 1982, $124.2 million was appropriated for title X activities of which $120.9 million was for family planning project grants. HHS awarded title X funds for family planning services to 223 direct grantees which funded 943 delegate agencies operating about 4,200 clinics. The type and number of grantees were as follows:

Types and Number of Title X Grantees

(as of April 1, 1981)

Public:	
State Health Departments	36
County Health Departments	33
City Health Departments	7
Trust Territory Health Departments	6
	82
Other nonprofit:	
Coordinating Councils	90
Planned Parenthood Affiliates	31
Hospitals	12
Universities	8
	141
Total	223

Family planning services provided by these grants typically include:

- -- Physical examinations.
- -- Laboratory tests.
- -- Education and counseling concerning reproductive health and methods of birth control.
- -- Prescribing and distributing contraceptives.
- -- Sterilization.
- -- Pregnancy tests.
- -- Pregnancy counseling.
- -- Infertility services.

- -- Special services for teenagers.

Most clients of title X-sponsored clinics are not pregnant and generally receive only physical examinations, education on contraceptive methods, and services related to birth control. In 1978, the latest year for which national data were available, about 162,000 of the 1,466,000 women (or 11 percent) making their first visit to family planning clinics received pregnancy tests.

STATUTORY RESTRICTIONS ON ABORTION-RELATED ACTIVITIES AND LOBBYING

Activities related to abortions and lobbying are restricted by Federal laws. Section 1008 of title X states that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." Restrictions on lobbying primarily stem from provisions in several annual appropriations acts that provide that no appropriated funds shall be used by grantees to influence legislation pending before the Congress.

OBJECTIVES, SCOPE, AND METHODOLOGY

Abortion-related activities

We reviewed HHS' program regulations and guidelines and other policy guidance implementing section 1008. We reviewed the grant awards and administration procedures followed in 6 of HHS' 10 regions. At each region, we interviewed program officials and examined grant documents to see how section 1008 was interpreted and implemented. These 6 regions administer grants totalling $98 million (or about 80 percent) of the title X funds.

To test for compliance with the HHS policies, we reviewed the activities of 14 family planning clinics in California, Kentucky, Massachusetts, Maryland, Ohio, Texas, Vermont, and the District of Columbia. (See app. II.)

At the 14 clinics, we reviewed local policies and practices; interviewed staff responsible for counseling, education and referral activities; ascertained the guidance furnished by HHS to title X recipients; and reviewed a limited number of client records selected randomly. In total we examined 474 records of pregnant clients to verify clinic counseling and referral practices. We do not consider this test to be representative of all title X clinics and the results should not be projected. We did not contact clients to obtain their views on the counseling provided because of concern about breaching client confidentiality.

We judgmentally selected the 14 clinics to provide for (1) geographic distribution of locations nationwide, (2) different types and sizes of title X recipients, and (3) rural and urban clinic settings. In selecting these locations, we avoided the title X recipients who were included in recently completed or ongoing audits by HHS' Inspector General.

In addition, to ascertain how title X recipients that also provide abortions as part of their overall operations comply with HHS guidance, we conducted limited audit work at certain other title X clinics that provide family planning services and abortions. These clinics were located in California, Ohio, and New York.

The demographic data requested on clients who are pregnant when they first seek services in title X clinics

are not collected by HHS' data systems, and comparative analysis of clients referred for abortions and educational materials used in public and private clinics could not be made. We did not undertake statistical tests to obtain the data because of the length of time that would have been required.

On February 22, 1982, HHS issued proposed regulations which would, among other things, require notification of the parents of unemancipated minors provided prescription methods of birth control. These proposed regulations are intended to implement section 931(b)(1) of the Omnibus Budget Reconciliation Act of 1981. At the time of our review these regulations had not been finalized.

Lobbying activities

Our review of title X recipients' lobbying activities focused on (1) identifying Federal laws, regulations, instructions, and other guidance applicable to lobbying by recipients and (2) determining whether recipients used Federal funds for lobbying. To ascertain whether grant recipients had sold or donated mailing lists to political candidates or organizations we held discussions with and reviewed the records of seven recipients. We found no indication that this practice occurred. In addition, we identified no Federal laws or regulations which prohibit this practice by grant recipients where it is not precluded in applicable grant documents.

We interviewed officials in HHS' Office of the Assistant Secretary for Management and Budget; Public Health Service's Office of Population Affairs, Bureau of Community Health Services, and Office for Family Planning; regional offices; and selected title X recipients

to identify Federal lobbying restrictions and guidance provided to recipients. In addition, we interviewed (1) officials of the Office of Management and Budget (OMB) to identify existing and/or proposed lobbying restrictions in OMB circulars and (2) representatives of the Internal Revenue Service to discuss lobbying restrictions imposed on nonprofit, tax-exempt organizations.

Our review included work at seven nonprofit title X recipients in California, New Jersey, New York, and the District of Columbia. (See app. II.) We visited five grantees--three coordinating councils and two Planned Parenthood organizations--and two other Planned Parenthood organizations operating as delegates of two of the coordinating councils. All received title X grants or subgrants for $125,000 or more. The five grantees included in our audit received about $8.4 million of title X funds during their most recent budget period. These grantees and delegate agencies were selected judgmentally considering, among other things, their size, and avoiding duplicating locations included in recent audits by HHS' Inspector General. Planned Parenthood organizations were included because the requestors asked questions specifically about such organizations. Coordinating councils--nonprofit recipients covered by the same OMB circulars as Planned Parenthood organizations--were included so that a range of family planning organizations was represented. The largest delegate agency of two coordinating councils was also reviewed. The organizations reviewed are not statistically representative of title X grant recipients.

At the recipient level we interviewed the executive director, financial director, board members, and other representatives to ascertain whether they lobbied and

whether title X program funds were used. We reviewed grant applications and budgets, financial expenditure reports, and audit reports and traced selected expenditures to source documents to ascertain whether they were related to lobbying activities. We also reviewed correspondence files, board minutes, and annual reports to the Internal Revenue Service to identify potential lobbying activities.

Our audit approach varied somewhat for each grant recipient because they had different accounting systems, received grants covering different periods, and were organized differently. In all cases, however, we reviewed selected expenditures made during January to June 1981, the period when the Congress was considering incorporating the title X program into a block grant, and during which time several bills were being considered in the Congress to limit the availability of abortions. We believe lobbying, if it occurred, would most likely have occurred during this period.

Our review did not include work at Planned Parenthood Federation of America because (1) according to HHS officials, the Federation did not receive title X funds during the period covered by our review and (2) as agreed with the requestors' offices, the results of our work on lobbying activities at the seven grant recipients did not indicate that further work was warranted.

Comments were obtained only from HHS and not from individual grant recipients included in our review.

As agreed with the requestors' offices, no work was done to determine how the effectiveness of the program can be evaluated because the title X program was being considered for inclusion as part of a block grant.

Our review was conducted in accordance with the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

CHAPTER 2

CONGRESSIONAL CLARIFICATION OF ABORTION RESTRICTIONS IS NEEDED

HHS' policy allows title X recipients to use organizational techniques to insulate the title X family planning program activities from abortion activities prohibited by section 1008, thereby not jeopardizing their eligibility for title X funds. That policy, established in 1971, stems from HHS' position that the restrictions of section 1008, prohibiting the use of title X funds "* * * in programs where abortion is a method of family planning" are only applicable to that part of the recipient's activities supported with title X funds. HHS' interpretation has created the impression, in some instances, that federally funded title X family planning clinics are engaging in prohibited activities.

In view of the sensitivity of the abortion issue and concern over how Federal family planning funds may be used, the Congress may want to clarify the intent of section 1008.

ORGANIZATIONAL ARRANGEMENTS USED BY SOME FAMILY PLANNING CLINICS

HHS estimates that about 74 organizations (46 hospitals, 21 Planned Parenthood affiliates, 4 other

nonprofit organizations, and 3 public health departments) receiving title X funds also perform abortions at clinics colocated with family planning programs.[1] While such organizations are expected to maintain physically separate family planning and abortion programs and separate records to account for each program, they are allowed to share facilities and staffs and to prorate common expenses. The examples below describe the organizational arrangements used by two title X recipients which enable them to provide both abortion and family planning services while still complying with HHS' policy.

Example #1

HHS has funded a nonprofit family planning organization located in Columbus, Ohio, since 1971. In 1978, the organization established a separate but controlled corporation for the sole purpose of providing first trimester abortions. The title X recipient has effective control of the corporation through interlocking trustees and the exclusive right and power to nominate and elect trustees.

The abortion and family planning clinics operate simultaneously on Wednesdays and Fridays in the same three-story building, with nothing on the exterior of the building indicating the existence of two separate operations. The abortion clinic leases space on the second floor from the title X recipient, and the family planning clinic occupies the third floor. Under an informal agreement, the abortion clinic pays the title X recipient a management fee for services of the executive

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[1] Information was not available on the number of family planning clinics that provided abortions at separate locations.

director and financial manager. Two other employees of the family planning clinic also work for the abortion clinic. The family planning clinic refers clients to the abortion clinic, but separate medical charts and patient accounts are established and maintained.

According to the executive director, the title X recipient established the separate corporation in order to avoid the appearance of violating restrictions imposed by section 1008. The abortion clinic performs about 1,000 abortions per year.

Example #2

HHS has funded a nonprofit organization in New York City which operates both abortion and family planning clinics. This title X recipient operates the abortion clinics under the same corporate organization, but separates the programs by scheduling clients at different times. At its Brooklyn clinic, for example, the scheduling was as follows:

	Abortion clinic hours	Family planning and abortion postoperative hours
Tuesday	8:30 to 10:00 a.m.	10:30 a.m. to 5:00 p.m.
Wednesday	8:30 to 10:00 a.m.	10:30 a.m. to 5:00 p.m.
Thursday	8:30 to 10:00 a.m.	10:30 a.m. to 5:00 p.m.
Friday	None	11:00 a.m. to 7:00 p.m.
Saturday	8:30 to 10:00 a.m.	10:30 a.m. to 5:00 p.m.

Both the family planning and abortion clinics are staffed by the same personnel, and the medical director for the family planning program generally performs the abortions for the clinic as well. The clinic director said that the abortion and family planning clinics' schedules did not overlap and that clients were not commingled.

The expenses of the clinic operations are maintained in separate accounts. All direct costs are charged specifically to family planning, abortions, or laboratory services as appropriate and indirect costs are prorated. Unlike the operation in the Ohio example, separate medical charts and patients accounts are not maintained, and all abortion clients are counted as family planning clients in the HHS reporting system. In 1980 the Brooklyn clinic served 4,462 contraceptive clients and performed 2,341 abortions.[1]

BASIS FOR HHS' POLICY

HHS' policy which permits funding organizations which operate abortion clinics outside the title X program is based on its assessment of the legislative intent. According to HHS' General Counsel, the most significant expression of that intent is contained in the Conference Report accompanying the Senate bill which eventually became Public Law 91-572. The Conference Report contained the following statement:

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[1] Because questions were raised during a previous GAO review as to whether certain practices at this clinic were in conformity with HHS' interpretation of section 1008, GAO sent a letter of inquiry to HHS. Using information obtained during an audit by the Inspector General, HHS' Office of General Counsel reviewed the concerns raised in our letter and concluded no violations of section 1008 were indicated at the clinic.

"It is, and has been, the intent of both Houses that the funds authorized under this legislation are used to support preventive family planning services, population research, infertility services and other related medical, informational, and educational activities. The conferees have adopted the language contained in Section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. The legislation does not and is not intended to interfere with or limit programs conducted in accordance with State or local laws and regulations which are supported by funds other than those authorized under this legislation."[1] (Underscoring added.)

In addition, HHS considers the statement on the floor of the House by the sponsor of section 1008 to be another major source of congressional intent:

"Mr. Speaker, I support the legislation before this body. I set forth in my extended remarks the reasons why I offered the amendment which prohibited abortion as a method of family planning * * *"

* * * * *

"With the 'prohibition of abortion' the committee members clearly intended that abortion is not to be encouraged or promoted in any way through this legislation."

[1] Conference Report, H. Rep. No. 91-1667, December 3, 1970, pages 8 and 9.

* * * * *

"Programs which include abortion as a method of family planning are not eligible for funds allocated through this Act."[1] (Underscoring added.)

Based on these expressions of the congressional intent, HHS has adopted the view that section 1008 prohibits (1) the provision of abortion as a method of family planning and (2) activities that promote or encourage the use of abortion as a method of family planning--but only when included in "programs" funded by title X.

Implementation of HHS' policy position at the local level can leave the impression that title X funds have been improperly used when recipients also operate abortion clinics. For example, HHS region V received a letter alleging that the abortion clinic operated by the Ohio organization discussed in example #1, "* * * invites the abuse of public funds in terms of channeling federal monies into the operation of an abortion clinic * * *." The individual was advised by HHS regional officials:

"* * * that to persons not intimately familiar with a given situation, the operation of an abortion facility at the same site as a federally sponsored family planning clinic brings to mind the possibility of inappropriate sharing of resources and undue influences on family planning services * * *."

[1] 116 Cong. Rec. 37375 (1970).

Thus, the HHS policy permits title X recipients to organize so as to conduct abortion activities under a separate "program" without jeopardizing their eligibility for title X funds.

MATTERS FOR CONSIDERATION BY THE CONGRESS

HHS' interpretation of section 1008 allows title X recipients to use non-title X program funds to carry out abortion-related activities which would not be allowed as part of the title X program, so long as the abortion activities are organizationally separated from the title X family planning services.

Because of the sensitivity of the abortion issue and the concern over how Federal family planning funds may be used, the Congress may want to provide guidance to HHS to clarify the intent of section 1008 if it does not want title X funds to go to organizations providing abortions.

CHAPTER 3

FAMILY PLANNING CLINICS NEED FORMAL GUIDANCE ON ABORTION-RELATED MATTERS

We found no evidence that women had been advised by title X grantees to have abortions or that title X funds were used to pay for abortions. However, some title X recipients' practices raised questions as to whether they comply with certain title X restrictions on abortion-related activities.

The questions stem from the fact that HHS has not issued formal policy guidance interpreting section 1008. Instead, HHS has relied on a series of legal opinions that often "draw a fine line" between allowable and unallowable activities and these opinions have not always been communicated to all title X recipients.

HHS' INTERPRETATION OF SECTION 1008

Since early 1971, HHS has taken the position that section 1008 prohibits activities that encourage, promote, or advocate abortion, as well as the use of abortion as a method of family planning, if they are carried out as part of the program supported with title X funds. These policy positions, based on the internal HHS General Counsel opinions, have not been formalized and incorporated into program regulations and/or guidelines.

Based on HHS' legal opinions, the following types of activities related to abortions are allowable under title X programs. Recipients may

- provide information about abortion services;
- provide the name, address, and telephone number of abortion providers;
- collect statistical data and information regarding abortion;
- inspect facilities to determine their suitability to provide abortion services; and
- pay dues to organizations that advocate the availability of abortion services.

Recipients may not

- provide counseling that encourages a person to

obtain an abortion,
- -- provide transportation to an abortion center or provider,
- -- provide proabortion speakers to debate the issues in public forums,
- -- advocate the need and suitability of abortion service in the community,
- -- produce or show movies that tend to encourage or promote a favorable attitude toward abortion,
- -- provide abortion as a suitable backup method of family planning,
- -- make specific appointments or referrals for an abortion unless medical conditions warrant,
- -- bring legal action to liberalize abortion-related statutes, and
- -- pressure local governing bodies to change restrictive abortion policies.

HHS' General Counsel has also concluded that, when title X recipients conduct abortion activities which would not be permissible if they were part of the grant-supported program, the recipient must ensure that the title X-supported program is separate and distinguishable from the abortion activities.

This position is contained in the following excerpt from an HHS legal opinion.[1]

> "It is recognized that in some situations, the abortion element in a program of family planning services may bulk so large and be so

[1] Memorandum GC (Mangel) to DASPA (Hellman), "Abortions as a Method of Family Planning--Section 1008 of the Public Health Service Act," April 20, 1971, DF#38B.

> intimately related to all aspects of the program as to make it difficult, if not impossible to separate the eligible and non-eligible items of cost. In such a case, we think a grant for the project would be legally questionable.
>
> "In other words, a mere technical allocation of funds, attributing Federal dollars to non-abortion activities and other dollars to abortion activities, in what is otherwise a discrete project for providing abortion services, would not, in our opinion, be a legally supportable avoidance of the section 1008 prohibition.
>
> "In our opinion, the activities (abortion and non-abortion) must be so separated as to constitute separate programs (projects). As we have already indicated, our conclusion does not require separate grantees or even a separate health facility. However, neither do we think that separate booking [sic] entries alone will satisfy the spirit of the law."

Over the years a fine line between allowable and unallowable activities has evolved as illustrated by the following examples:

- -- Recipients may use title X funds to pay the cost of inspecting abortion facilities to see that they meet national Planned Parenthood Federation of America standards, but may not make an appointment for or direct clients to those facilities.

- -- Title X funds may be used to pay dues to organizations that advocate the provision of

abortion as a backup for contraceptive failure, but may not be used to advocate the need for and suitability of abortion in the community.

- Title X funds may not be used to pay transportation costs for women to go to abortion clinics, but recipients may provide or arrange such services under that part of their operation not supported with title X funds. Similarly, the recipients may, under their separate programs, make loans to women to pay for abortions.

HHS' PROGRAM REGULATIONS AND GUIDELINES DO NOT REFLECT ITS POLICY ON ABORTION RESTRICTIONS

The position that section 1008 not only prohibits abortion as a method of family planning, but also prohibits activities which promote or encourage a favorable attitude toward abortion as part of the title X program has not been incorporated into HHS' regulations or guidelines. In contrast, HHS relies on its program regulations[1] and guidelines to provide guidance on other major policies to title X recipients.. In effect, HHS' regulations that spell out overall policy and implement provisions of the law and corresponding program guidelines that elaborate on the law and regulations in operational terms do not contain the specific policy guidance concerning section 1008 needed by title X recipients.

We could not determine from discussions with HHS'

[1] 42 C.F.R. Part 59.

officials the rea[sons] why HHS elected to exclude from its regulations and guidelines its position on the scope of prohibitions in section 1008. HHS' regulations (dated June 1980) and its prior regulations simply state that title X projects shall not "* * * provide abortion as a method of family planning." The policy that section 1008 also prohibits activities which promote, encourage, or advocate abortion are not mentioned in HHS' regulations. Also, the HHS program guidelines for family planning guidelines for family planning services refer to the title X program regulations with no elaboration on the meaning of section 1008.

HHS, however, has periodically issued memorandums to its regional program administrators containing Office of General Counse[l] interpretations of section 1008. Five of six regions we visited had transmitted this information to grantees, but only 3 of the 10 grantees passed it on to their delegate agencies and clinics. Of 14 clinics visited, only 6 had received HHS' legal interpretations of section 1008.

While this process made HHS' policy available to some title X clinics, the policy was nevertheless not included in the regulations and guidelines that grantees are required to follow as a condition of their grants. For example, the title X grantee in Los Angeles, according to its executive director, has received no written guidance from HHS on interpreting section 1008. This grantee, one of the largest nationally, had 26 delegate agencies that operated 94 clinics.

SOME COUNSELING AND REFERRAL PRACTICES MAY NOT BE APPROPRIATE

Under the HHS program guidelines, pregnant

women should be offered information and counseling regarding their pregnancy. The guidelines state that individuals requesting information on options for managing an unintended pregnancy are to be given nondirective counseling[1] on the options available and referred upon request, including being referred to abortion providers. At the clinics reviewed, the number of pregnant clients coming to clinics for their first visit represented between 5 and 69 percent of the clientele.

At 10 of the 14 clinics visited, counseling was available through the title X-supported programs. At the four other clinics, one did not provide any counseling and the other three provided counseling, but not as part of their title X programs. Officials at all clinics which provided counseling indicated that they provided only nondirective counseling in accordance with HHS guidelines. Referral practices varied from clinic to clinic, and some clinics did not comply with HHS' policy position. We did not find any evidence, however, that pregnant women were advised to have abortions.[2]

Counseling practices

Typically, counseling of pregnant women occurred after clients received tests that confirmed their pregnancy. When the pregnancy was desired, clients were generally advised to seek prenatal care and given referrals if needed. If a woman indicated the pregnancy

[1] Nondirective counseling is the provision of information on all available options without promoting, advocating, or encouraging one option over another.

[2] None of the clinics reviewed provided or referred any client for menstrual extraction procedures.

was unintended or not wanted, counseling was generally provided. Officials at the 13 clinics offering counseling said that nondirective counseling was available on the following options:

-- Prenatal care and delivery.

-- Infant care, foster care, or adoption.

-- Pregnancy termination.

The pregnancy counseling provided by clinics varied as shown below:

-- Seven clinics counseled clients, but only on the option they decided to pursue.

-- Four clinics counseled clients on all options when the client expressed that the pregnancy was unintended or she was unsure of what to do.

-- Two clinics counseled all pregnant women on all options available to them.

One of the 13 clinics offered followup counseling to clients referred for abortions, although officials at all clinics said postabortion counseling was available if requested by the clients.

According to HHS' headquarters officials, all options do not have to be discussed, but they believe it is "professionally incumbent" upon the counselors to discuss other options with women who say they are only interested in abortions. When a woman is interested in continuing her pregnancy, HHS' officials said that

abortion should not be discussed.

Eleven of the clinics required their counseling staffs to take training and/or participate in an appropriate orientation course covering problem pregnancy counseling and referral policies. The academic background of the staff providing counseling varied. Registered nurses and nurse practitioners often provided the counseling to pregnant clients. At some clinics, counselors had advance degrees in the fields of psychology or social work, and at other clinics the counselors had no formal credentials or degrees in areas related to counseling. Typically, the counselors had not received formal training in counseling pregnant women, but at most clinics counselors had some formal or in-service training in related areas, such as crisis counseling.

We were advised by clinic officials that the topic of abortion and counseling often came up spontaneously during in-service training and other courses. Clinic officials said they always emphasize a nondirective and unbiased approach to counseling pregnant women. Interviews with several counselors showed that they were aware of restrictions against encouraging or advising clients to have abortions.

Questionable counseling practices

Seven clinics did not provide counseling on all options available to pregnant women. At one clinic, women were required to complete paperwork before their pregnancy tests and preselect how they intended to deal with their pregnancy. If they chose to continue the pregnancy, they were counseled on that option. If they checked abortion, they were counseled only on that choice. Six other clinics, which did not require

prepregnancy test decisions, did not routinely counsel women on other alternatives if they had decided on abortion. Based on the HHS guidelines which recommend that all options be discussed with clients deciding on abortion and HHS' officials views that it is "professionally incumbent" to discuss all options, these practices are questionable.

Referral process

When clients are counseled and choose to terminate their pregnancies, referrals may be made to abortion providers. The extent to which clinic personnel can assist clients in making abortion arrangements is limited, according to HHS' interpretation of section 1008. HHS' referral policy, however, is not clearly stated in the program regulations or guidelines and certain abortion referral practices by title X recipients raise questions as to whether they go beyond the "mere referral" HHS maintains is permitted under the law.

Title X regulations require that each project provide clients with medical services related to family planning and make referrals to other medical facilities when medically indicated. Therefore, if continuing a pregnancy would endanger the mother's life, a referral to a provider who might recommend or provide an abortion would be medically indicated. However, the regulations are silent on the referral process for abortions in other instances.

Since 1971, HHS has relied on legal opinions that applied the concept of "mere referral" to the restriction imposed by section 1008. Under this concept, title X program funds may not be used to make an appointment for a woman, to provide transportation, or to take other

affirmative action to secure an abortion.

The title X program guidelines, issued in 1981, provided that women needing services, which are beyond the ability of the clinic to provide, should be referred to other providers for care. This provision, however, as it relates to abortion referrals, does not reflect the "mere referral" concept traditionally held by HHS. Although HHS' officials advised us that the "mere referral" concept has been agency policy on abortion referral, they did not explain why this policy had not been included in program regulations or guidelines.

We reviewed several clients' charts to determine, among other things, the referral outcomes at the clinics visited. The results of our review cannot be projected, but provide a limited perspective on referral outcomes at these particular clinics. The results are shown on the next page.

Some clinic practices may go beyond "mere referral"

Referral practices varied, but most clinics provided some type of information on the sources of abortion services to clients desiring to terminate pregnancies. By applying HHS' policy, we identified the following practices that could be construed to go beyond the "mere referral" policy:

-- Four clinics provided clients brochures prepared by abortion clinics. Some of the HHS regional staff were not sure this practice was acceptable, while others felt it was reasonable and within the spirit of HHS' policy.

-- At two clinics, clients seeking abortions were allowed to use the telephone to make appointments for abortions. HHS' officials were not sure this practice was within the spirit of the HHS policy because it went beyond the concept of providing information with no further affirmative action.

[Table omitted]

-- At one clinic, appointments for abortions were made for clients who did not speak English. (The HHS Inspector General identified two other instances of counselors making abortion appointments for clients.)

-- At one clinic, the title X recipient provided women loans for abortions from nonprogram funds; however, administrative costs associated with the referral and loans were charged to title X program costs. (A similar observation was noted by HHS' Inspector General.)

The Office of the Inspector General also identified that several title X clinics in Indiana provided and witnessed the signing of consent forms required by an abortion clinic. This practice is prohibited by section 1008, according to HHS, since it could be considered promoting abortion. The title X grantee indicated that the consent form was completed only after women had decided to have an abortion and that the practice simply facilitated the abortion decision and did not encourage or promote abortion. HHS regional officials ordered the practice stopped as part of the title X program, and the recipient told us it had passed the instructions to its delegates.

SOME EDUCATIONAL MATERIALS USED IN TITLE X CLINICS MAY BE IMPROPER

Five clinics routinely offered educational materials to family planning clients that presented abortion as a backup if a contraceptive method failed. Other clinics, however, did not use educational material referring to abortion since they felt it could be construed as encouraging or promoting a favorable attitude toward abortion. Examples of educational material included:

-- One clinic used a film about birth control methods and sterilization that included a section that presented abortion as a legal alternative in the event of an unwanted [pregnancy]. This film was shown to all clients entering the large Texas clinic for family planning services. At our request, HHS' regional officials watched the film and concluded the film did not encourage abortion as a method of family planning, but could be construed to be encouraging a favorable attitude about abortions.

-- Four of the 14 clinics provided or made available to all clients entering the family planning program handout material that discussed abortion. Typically, handout materials listed various birth control methods with the barrier method and early abortion in the event of a failure as an alternative method. According to an HHS General Counsel opinion, section 1008 prohibits the use of abortion as a backup method of family planning and therefore cannot be offered.

MONITORING FOR COMPLIANCE WITH SECTION 1008 IS LIMITED

HHS' officials responsible for monitoring the title X program have generally not taken inspection trips solely to check for compliance with section 1008, but they claimed to have looked at compliance with all program guidelines and requirements in instances where onsite inspections have been conducted. In the absence of HHS' regulations and guidelines that elaborate national policy established by section 1008, efforts to closely monitor compliance are difficult.

Officials at four HHS regions said that travel budget cuts and lack of personnel have prevented regular monitoring trips to all grantees. One official advised us that the high visibility of the abortion issue tends to surface possible gross violations and reduce the need for regular surveillance of grantee activities.

HHS' policy requires that all allegations of violations of section 1008 be investigated by a team composed of personnel familiar with all aspects of the title X program and overall HHS' grant administration. We were advised that only one investigation had been made. In this case, the title X recipient was alleged to be

-- encouraging or promoting abortion by administering a petition calling for liberalized abortion laws,

-- providing literature that promoted a favorable attitude about abortion in a common waiting room for family planning and abortion clients, and

-- facilitating abortions by negotiating reduced fees and making arrangements for abortions.

HHS' investigation found that the title X recipient carried out the alleged activities, but could not determine if they were a part of the title X-funded program. The grantee was advised to remove the petitions and abortion materials from the waiting room and to set up a bookkeeping system to keep costs separated. The investigation concluded the practices were minor and technical in nature and did not warrant further action.

Until 1981, HHS' Office of the Inspector General had not made a programwide review of compliance with section 1008. In 1981 the Inspector General reviewed 32 title X grantees, focusing on lobbying and abortion activities. The Inspector General review has been completed and reports on individual recipients have been issued. In addition to the practices discussed on page 18, at one grantee the Inspector General questioned about $400 for malpractice insurance for an abortion clinic charged to the program funded, in part, by title X.

CONCLUSIONS

Since 1971, HHS has held that the abortion prohibition went beyond the literal reading of section 1008 and also prohibited activities which promoted or encouraged abortions. However, HHS has neither clarified its policy nor used its regulations and guidelines to communicate to title X recipients its position on section 1008. As a result, a degree of uncertainty exists and some grantees' practices may go beyond what, in HHS' opinion, is permissible under section 1008.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary establish clear operational guidance by incorporating into the title X program regulations and guidelines HHS' position on the scope of the restriction in section 1008.

In doing so, we recommend that the Secretary consider the grantee practices discussed in this report and in the Inspector General's reports with a view toward providing as explicit guidance as possible on the activities that are and are not allowed.

AGENCY COMMENTS

HHS concurred with our recommendation. The Secretary plans to direct the Assistant Secretary for Health to include in title X program guidelines an explanation of the Department's position on the implementation of section 1008. (See app. III.)

CHAPTER 4

TITLE X RECIPIENTS NEED MORE SPECIFIC GUIDANCE ON LOBBYING

Most of the title X recipients reviewed for lobbying were involved in some types of lobbying activities. Generally, these activities were not paid for with appropriated funds or charged to the title X program and were therefore not subject to Federal lobbying restrictions. However, some title X recipients used program funds to pay dues to organizations that lobby--a

questionable expenditure in light of current legislative restrictions and HHS' policies. In addition, some recipients spent small amounts of title X program funds for lobbying.

The current OMB and HHS guidance regarding the use of program funds for the payment of dues is inconsistent, and guidance on lobbying does not specifically identify the types of activities that constitute lobbying and are therefore unallowable as title X program expenditures.

FEDERAL RESTRICTIONS ON LOBBYING

Federal law prohibits grant recipients from using Federal funds to lobby the Congress--that is, to engage in activities designed to influence legislation or appropriations pending before the Congress. Under HHS' policy, lobbying costs are not normally allowable program expenses. However, HHS has not issued specific guidance which identifies activities that constitute lobbying.

Legislative restrictions

The use of appropriated funds, including title X funds, to lobby the Congress is prohibited by Federal appropriations legislation. Since the early 1950s, an annual appropriation act restriction has prohibited the use of Federal funds by all executive agencies, departments, and government corporations for "grass roots" lobbying the Congress--appeals addressed to the public to contact the Congress to influence pending

legislation.[1] Also, since fiscal year 1974, HHS, in its own annual appropriations legislation, has been prohibited from using appropriated funds for publicity and propaganda to support or defeat legislation pending before the Congress, except when officials are presenting views to the Congress that affect HHS' activities and policies. The scope of these restrictions was expanded by HHS' fiscal year 1979[2] appropriations act which prohibits HHS' grant and contract recipients from using HHS' appropriations for lobbying the Congress as follows:

> "No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient or agent acting for such recipient to engage in any activity designed to influence legislation or appropriations pending before the Congress." (Underscoring added.)

These restrictions in Federal appropriations legislation apply only to lobbying the Congress.

Administrative restrictions

HHS' and OMB's guidance implementing Federal lobbying restrictions are inconsistent and lack specificity.

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[1] Initially this antilobbying appropriation restriction was contained in the Independent Offices Appropriation Act; however, in recent years, it has been included in the annual Treasury, Postal Services, and General Government Appropriation Act.

[2] This restriction was not applicable for title X recipients until 1980 because title X appropriations were not included in HHS' fiscal year 1979 appropriations, but rather in a separate Continuing Resolution.

HHS' guidance generally prohibits the payment of any lobbying costs with program funds, which includes not only title X grant funds, but also non-Federal funds used by recipients to meet their grant matching shares and income generated as a result of the grant. This guidance applies to the use of program funds not only for lobbying at the Federal level, but also at the State and local levels. The prohibition was set forth in an HHS Grants Administration Manual Circular issued May 25, 1979, which stated that the costs of lobbying expenditures are normally unallowable because they do not benefit the work performed under the grant.[1]

HHS' regulations require title X grant recipients to follow applicable OMB guidance in the administration of their grants. According to the OMB circular setting forth cost principles that must be followed by State and local government grant recipients,[2] program funds can be used to pay dues to civic, business, technical, and professional organizations, but only if such organizations do not devote a substantial part of their activities to lobbying. However, this restriction is not included in OMB's circulars setting forth cost principles for universities and nonprofit organizations[3] nor HHS' cost principles for hospital grant recipients[4] -- both of which simply provide that dues are an allowable program

[1] In some situations, expenses associated with lobbying at the State and local levels would be allowable program charges, such as when grantees' programs include an advocacy function.

[2] OMB Circular A-87.

[3] OMB Circulars A-21 and A-122.

[4] HHS issues cost principles for hospitals, not OMB. See 45 CFR Part 74.

expense, without distinguishing between organizations that lobby and those that do not. As a result, nonprofit recipients do not have the same lobbying restrictions on dues as public recipients.

Most importantly, neither HHS' nor OMB's principles specifically identify activities that constitute lobbying and that are therefore unallowable as program charges.

LOBBYING BY TITLE X RECIPIENTS

All seven title X recipients reviewed for lobbying had incurred expenses that, in our opinion, raised questions as to adherence with Federal restrictions. Two recipients lobbied, but we could not determine from their records whether program funds were used. Most lobbying expenditures of the other five recipients did not involve program funds and were therefore not subject to Federal restrictions. However, of these five

-- all used program funds to pay dues to organizations that lobby and

-- two used small amounts of program funds to lobby at the Federal and/or State level.

Dues paid to organizations that lobby

Six recipients, including five who clearly used program funds, paid dues to organizations that lobby at the Federal level. The recipients' program expenditures for such dues ranged from $25 to over $27,000 during the period covered by our review, and the combined expenditures of the five recipients was about $42,000. Although the payment of dues by nonprofit organizations

is an allowable program expense, the use of program funds to pay dues to organizations that lobby substantially for or against pending legislation that affects the grant program is questionable in light of current legislative prohibitions against using appropriated funds for lobbying and HHS' policy that generally prohibits program expenses for lobbying.

We discussed the payment of dues to organizations that lobby with three recipients. Officials of two recipients said dues to professional organizations should be allowable because such organizations provide many needed services. One executive director told us that he did not think the payment of dues to lobbying organizations is currently prohibited by HHS and that it should not be. However, to ensure the allowability of expenditures for dues to an organization that lobbied at the State level, he noted, in his letter transmitting payment, that his dues should be used for educational purposes. The executive director of the third recipient, rather than having a firm position, sought guidance as to whether he should stop paying dues with program funds.

Program funds used for lobbying activities

Two recipients spent program funds for lobbying at either the Federal or the State level. Lobbying at the Federal level is prohibited by Federal law and administrative policy. Lobbying at the State level generally is prohibited by administrative policy only. As shown below, the title X program expenditures associated with lobbying activities were small and, in some cases, indirect.

At the Federal level:

-- Two recipients spent program funds for transportation, lodging, and other expenses associated with attending conferences in Washington, D.C., during which officials visited Members of Congress and/or their staff and lobbied against pending legislation to incorporate title X into a block grant. About $200 was spent for this activity.

-- One recipient incurred undetermined costs associated with writing the Congress to lobby against pending legislation. The costs involved salaries and expenses related to preparing and distributing the correspondence.

-- One recipient displayed a poster and distributed post cards at a title X clinic encouraging clients to write their congressional representatives to urge them to vote "pro choice" on pending legislation. Costs associated with this activity were too obscure to calculate. However, HHS holds that title X recipients are not to advocate abortions or even foster a favorable attitude toward abortions.

At the State level:

-- One recipient incurred costs for attending a conference that involved lobbying at the State level. About $113 was spent on this activity.

-- One recipient provided space for about 6 weeks in a title X clinic to an organization involved in lobbying at the State level and, as a result,

program funds were indirectly involved.

Recipients did not agree with our observations that the costs of these activities were unallowable program expenditures because they were associated with lobbying. For example, one executive director said he thought that meeting and corresponding with Members of Congress was more an educational activity than a lobbying activity. He told us that he had not received clear guidance explaining activities which constitute lobbying. Another executive director disagreed that displaying the poster was an improper activity because (1) Federal funds were not used to print it and (2) it was more an advertisement than a lobbying effort.

HHS' EFFORTS TO CLARIFY LOBBYING GUIDANCE

HHS has recognized the need to clarify guidance provided recipients on lobbying and has begun taking corrective measures. In response to inquiries about the possible misuse of Federal funds for lobbying, the Secretary of HHS asked the Assistant Secretary for Management and Budget to identify ways to reduce possible abuse. In June 1981, the Assistant Secretary suggested several steps that could be taken, including (1) making grant recipients aware of applicable restrictions, (2) increasing monitoring, and (3) identifying clearly activities considered unallowable.

In October 1981, HHS recommended that OMB review its cost principles to clearly set forth unallowable lobbying activities and to prohibit all recipients, including nonprofit organizations, from using program funds for dues to organizations that devote a substantial part of their activity to lobbying. HHS believes that lobbying

restrictions should be set forth on a Government-wide basis and, therefore, guidance for nonprofit grantees should be issued through OMB. However, we were told that, if OMB does not revise its cost principles, HHS will issue restrictions on lobbying as part of its policy guidance. In late June 1982, OMB officials told us no final determination had been made on how its cost principles will be changed to reflect lobbying restrictions.

CONCLUSIONS

Clear Federal guidance is needed both to insure that title X program funds are not used for lobbying and to preclude unnecessary controversy over whether grantees are violating Federal restrictions. The move to revise and make more specific the cost principles applicable to all Federal grantees is the appropriate mechanism to achieve these ends. Until this is done, however, HHS should provide title X grantees interim guidance concerning the activities that constitute lobbying and are therefore unallowable as program expenditures.

RECOMMENDATION TO THE SECRETARY OF HHS

Pending revision of Federal cost principles, we recommend that the Secretary provide interim guidance to title X recipients on activities that constitute lobbying and are unallowable as title X program expenditures.

AGENCY COMMENTS

HHS concurred with our recommendation. In the near future, HHS plans to issue proposed regulations defining lobbying activities that are unallowable in its programs, including title X programs. (See app. III.)

[APPENDIX I to GAO Report]

September 8, 1981

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

As you know, the Title X Family Planning program has not been consolidated into a block grant as proposed by the President but has been reauthorized as a categorical program for another three years. The Committee on Labor and Human Resources and its Subcommittee on Aging, Family and Human Services are very much interested in the operation of this program and plans for extensive oversight of the program.

During the last several months, Committee staff have been discussing three areas of interest regarding the Title X program with your representatives. These areas are (1) use of Title X funds for political lobbying, (2) use of Title X funds for abortion or abortion referrals, and (3) the overall effectiveness of the program. We understand that you have done some preliminary audit work in the first two of these areas. Now that the budget reconciliation process has been completed, we have identified several specific concerns in each of these three areas.

Following are several questions of interest to us in these areas. To the extent data are available, we would

like to have information on all Title X grantees. In cases where national data are not available, we would like you to select a sample of grantees or clinics, including, as appropriate, coordinating councils, health departments, and planned parenthood affiliates. We understand you have already reported on political activities of some community action agencies, a number of which are Title X grantees.

USE OF TITLE X FUNDS FOR POLITICAL ACTIVITIES

1. What Federal laws and regulations or instructions or guidance issued by Federal agencies pertain to lobbying activities by Title X grantees and clinics?

2. Is there any evidence that Planned Parenthood Federation of America, or its affiliates has either donated or sold at minimal costs mailing lists to political candidates or organizations? Is there evidence that this represents a violation of Federal laws or regulations?

3. What types of political lobbying activities are Title X grantees or clinics carrying out, are Title X funds used, and are any of these activities prohibited by Federal laws, regulations, or instructions?

   Activities in question include such actions as advertising, direct mailings, voter registration, telephone canvassing or "hotlines", or payment of dues to lobbying organizations.

4. Is there any evidence that Planned Parenthood

Federation of America used Title X funds or any other federal funds for political lobbying activity during 1980 or 1981? Are dues collected from Title X funded affiliate organizations considered "Federal funds" for purposes of lobbying prohibitions? Is there any evidence that grantees are able to increase their political activities using funds "freed" by the presence of federal funds?

USE OF TITLE X
FUNDS FOR ABORTIONS
OR ABORTION REFERRALS

1. What activities has HHS identified as allowable or unallowable relative to section 1008 and how has HHS informed Title X recipients of these? What guidance or instructions has HHS issued to Title X grantees for abortion referrals?

2. How does HHS monitor Title X recipients for compliance with section 1008 and what enforcement actions has HHS taken relative to section 1008 during the last few years? Do HHS' monitoring actions appear adequate to detect compliance with section 1008? How many organizations receiving Title X funds perform abortions either at the same location where Title X services are provided or at separate locations?

3. How many Title X recipients has HHS found to be using Title X funds for abortions or abortion related services, including referrals? Have you or HHS identified any Title X recipients performing menstrual extractions without

performing pregnancy tests which may, in fact, be abortions?

4. In testifying before this Committee in March 1981, you indicated that one Title X grantee--Planned Parenthood of New York City--may not have been in compliance with section 1008 restrictions and that you would be referring this matter to HHS' Inspector General for further evaluation. When did you make this referral and what actions has HHS taken?

5. What steps do Title X clinics that perform abortions or make abortion referrals take to comply with section 1008? Do such organizations account for abortions and abortion referrals separately?

6. To the extent information is readily available or ascertainable,

   -- How many clients are pregnant when they first seek services at typical Title X clinics? How many of these clients are 19 or under?

   -- What are the marital status, age, and race of the above clients who seek or receive pregnancy counseling?

   -- Of the Title X clinic clients who seek or receive pregnancy counseling, how many are referred for abortions?

   -- How many clients referred for abortions have had a previous abortion? Please

break down by age and marital status.

7. Is there any evidence that clinic counseling is structured or presented to favor abortions over other alternatives?

8. What internal guidance or instructions on abortion referrals have Title X grantees developed and given to their personnel?

9. What training have Title X clinic counselors received regarding problem pregnancy counseling, including abortion referral?

10. What educational materials about abortion are offered by Title X funded clinics?

11. What process typically leads to an abortion referral in Title X funded clinics?

12. Do any substantive differences exist in the proportion of clients referred for abortion or in educational materials used regarding abortion between public and private Title X grantees?

13. Are clients referred for abortion by Title X clinics offered follow-up counseling?

14. What steps have HHS and Title X grantees and clinics taken to implement section 931 (b)(1) of the Omnibus Budget Reconciliation Act of 1981? This section requires Title X grantees and contractors to encourage family participation in project operations.

EFFECTIVENESS OF TITLE X PROGRAM

As you know, many claims have been made by Title X program components of the program's effectiveness in preventing unwanted pregnancy. In fact, proponents have recently stated that the Title X program saves over $2.00 for every $1.00 spent. Yet, with regard to adolescents, illegitimacy rates, abortion rates, and incidents of premarital sexual activity continue to increase dramatically. There are several ways effectiveness might be gauged. These should include encouraging involvement of parents and other family members when working with adolescents, and supporting local community standards with regard to these issues. We recognize that an in-depth evaluation of the effectiveness of the Title X program could be very costly and time-consuming. However, we would like GAO to determine how the effectiveness of the program could be evaluated, either comprehensively in one study or in phases. Proper attention should be given to the cost-benefit ratio claimed by proponents and to other outcomes of the use of Title X funds with which society must contend. After you have completed such an assessment, we would like to discuss the best approach for conducting the evaluation.

If, during the course of your work, you should need further guidance or information, please contact either Dr. Craig Peery on the Staff of the Labor and Human Resources Committee or the Staff Director of the Aging, Family and Human Services Subcommittee, Miss Cynthia Hilton. Thank you for your cooperation.

Sincerely,

/s/	/s/
ORRIN G. HATCH	JEREMIAH DENTON
Chairman	Chairman
Committee on Labor and Human Resources	Subcommittee on Aging Family and Human Services

JAD:km:ca

Enclosures

[Appendices II and III omitted.]

[End of GAO Report]

Letter from Congressman John D. Dingell, Chairman, Committee on Energy and Commerce, United States House of Representatives, to Otis R. Bowen, Secretary, Department of Health and Human Services (Oct. 14, 1987)

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515

October 14, 1987

The Honorable Otis R. Bowen
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

It was with great disappointment that I read the proposed regulations for family planning clinics which were published in the Federal Register on September 1, 1987. The regulations appear to sanction excessive intrusion into the private operations of facilities which receive funds under Title X of the Public Health Service Act; they also appear to restrict unduly the activities which Title X recipients can conduct with federal monies. I would like to take this opportunity to express my concern that the Department has taken a very narrow view of the legislative history of Title X and has used its narrow view to construct a biased interpretation of congressional intent for the program. At a personal level, I protest in the strongest possible terms the misuse

of my Floor statement from the debate during passage of the original family planning legislation in 1970. I request that this letter and its attachment be included as part of the formal comments on the proposed rules.

The Background section of the proposed regulations purports to establish congressional intent for the family planning set out in Title X. To establish congressional intent, your Department quotes two sentences from the 1970 Conference Report on Title X and three passages from my Floor statement on the original enacting legislation. The Department has conveniently ignored the intervening 17 years of congressional action on this issue. Since my statement was made, the Title X program has been reauthorized six times and has been the subject of at least 7 other pieces of legislation. Restrictions similar to those in the regulations have been specifically proposed and rejected during this period. An accurate legislative history would reflect the entire record.

In addition to relying on an incomplete legislative history, the Department has also quoted passages from my Floor statement out of actual and historical context to imply things that were not said and which may not be reasonably inferred. My statement was made in opposition to the use of Federal funds to support or encourage abortion as a form of birth control. The statement did not suggest, either expressly or implicitly, that family planning clinics should be prohibited from counseling pregnant women on any matter or referring them to appropriate facilities. Nor did the statement support the imposition of record-keeping, distinct facility requirements, constraints on political activity, or the taking of a negative oath by clinics. The proposed regulations erroneously suggest that the statement

somehow supported these goals.

I regret that the Department has succumbed to political pressure to apparently misinterpret the congressional intent for Title X and to propose the current set of regulations. I had been hopeful that the Department would abandon this regulatory approach last February when the Department reprimanded then-Deputy Assistant Secretary Gaspar for circulating a memorandum which promoted what appeared to be Ms. Gaspar's personal agenda regarding Title X by using the same misconstrued reasoning as is used in the regulations. I communicated my views on these issues directly to you in a February 6, 1987 letter. Since the meaning of that letter was apparently unclear, let me state clearly for the Administration that I opposed Ms. Gaspar's attempts to restructure Title X, I oppose the current regulatory efforts to restructure Title X, and I will oppose such efforts to alter the program in the future.

Sincerely,

/s/

JOHN D. DINGELL
CHAIRMAN

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

THE STATE OF NEW YORK, ET AL.,	:	
Plaintiffs-Appellants,	:	
- against -	:	**DECLARATION** Nos. 88-6204/06
DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,	:	
Defendant-Appellee.	:	

DECLARATION OF JOAN COOMBS

JOAN COOMBS states as follows:

1. I am the Executive Vice President of Planned Parenthood of New York City, Inc. ("PPNYC"), one of the plaintiffs herein. I make this declaration in support of plaintiffs-appellants' Motion for Stay and Injunction Pending Review on Writ of Certiorari.

2. PPNYC cannot and will not implement the new Title X regulations. To do so would be contrary to sound and established medical practice, would deprive women of the information to which they are entitled and which they need to make critical decisions about their health, and would violate the laws of the State of New

York.

3. Many of the Title X patients served by PPNYC, in accordance with Title X regulations, pay as much of the cost of the services they receive as they can afford. Under the new regulations these patients, paying in part with private funds, cannot receive the full counseling to which they are entitled under good standards of medical practice, the dictates of medical ethics, and the requirements of New York Law.

4. If the relief requested herein is not granted, PPNYC will, on December 1, 1989, lose $444,808 in Title X funding, or approximately 27% of the operating budget of its clinic at the HUB, its center in the South Bronx.

5. PPNYC does not have any cash reserve which could replace this loss. Nor can it pass the cost along to its patients. Raising almost $450,000 from the private sector--in addition to the nearly $4 million we must raise annually in order to avoid a financial loss and support our programs and services--would be virtually impossible.

6. If our Title X funds are withdrawn on December 1, PPNYC will face immediate chaos at its HUB clinic, cessation of services to many patients and the probable closing of the clinic, a clinic which, for more than a decade, has served medically indigent adults and teens at high risk of unintended pregnancy in one of the poorest congressional districts in the United States.

7. Because PPNYC's Title X program is closely integrated with related health services at the HUB clinic, its loss would have an impact far beyond the patients directly served with Title X funds. Loss of these funds would have a devastating effect on the ability of the

entire HUB center to function. Elimination of Title X funding from the varied but fragile foundation of public funding which supports many of the HUB's programs would, as a practical matter, result in the cessation not only of family planning services, but the dismantling of many other critical medical and non-medical services provided to this high risk population--AIDS testing and counseling, prenatal care, well baby care, comprehensive physical examinations, and vocational programs for out-of-school youth.

8. Approximately half of PPNYC's Title X grant supports a part of the cost of 36 employees, most of whom live in the South Bronx. Loss of the grant would, at a minimum, force immediate reorganization of the Center and the laying off of approximately 10-15 employees as well as per diem staff, including nurses and physicians (representing an additional cost of $47,000) who augment the family planning services provided by the regular staff.

9. Even with these cuts in its Title X program and staff, it is doubtful whether PPNYC could maintain its other programs and health services at the HUB if Title X funding were lost. Critical overhead expenses, including rent, telephone, medical liability insurance, and security guards, are funded proportionately with Title X funds.

10. The areas served by the HUB have been rocked by decades of neglect, unintended teenage pregnancy, low infant birthweight, crime, drug abuse, child abuse, deteriorating housing stock, and upwardly spiraling rates of school dropouts. In the midst of these grim indicators of the quality of life as it is lived in the South Bronx, the HUB acts as an oasis for medically

indigent young people and adults. It serves as a comprehensive reproductive health center, a learning center, and a recreation center. It is a safe place to come, for many it is the first stop on the way to comprehensive health services. The following are snapshots of the communities it serves:

Community District 1
(Mott Haven, Melrose, Port Morris)

Ninety-four percent of the 80,000 people living in this community are either Black or Hispanic; 30 percent are between the ages 5-17. The median income per family is $7,810, while 44 percent of these families live below the poverty line. More than 45 percent of the population receive some form of public assistance. In a recent study, Mott Haven recorded the highest percentage of teen births, at 67.9 percent, in the Community Board. In addition, Mott Haven has the worst record for prenatal care in New York City--more than 48 percent of the mothers who delivered in the community did not receive adequate prenatal care.

Community District 2

Ninety-seven percent of the population of this community is Black or Hispanic; the average median income is $7,200 and more than 54% of the population receives some form of income assistance. Until recently, the HUB had not been able to extend its services to the Hunt's Point area. But, in 1988, a National Priorities grant through Title X permitted PPNYC to institute a model, innovative outreach,

education, and intervention program here, focusing on teens at extremely high risk of contacting and conveying AIDS--prostitutes and teens engaging in IV drug abuse. Hunt's Point, which includes the New York City Terminal Market, is the largest outer-borough gathering spot for juvenile prostitutes.

Word of PPNYC's program has already reached into the community at large and we are beginning to see increasing numbers of Hunt's Point residents at the HUB. The teens for whom the program was developed are using the family planning services of the HUB clinic; several young women who had run away from home because they thought they were pregnant were reunited with their families after pregnancy detection tests and counseling.

Community District 3
(Morrisania)

Of the 54,000 individuals living in this community, 98 percent are either Black or Hispanic; 52 percent receive some form of income assistance; and 46 percent live below the federal poverty line. The average median income is less than $7,500 annually.

11. The HUB provided family planning services for 6,274 low-income women and teenagers in 1988. Of these, 2,317 were under 20 years of age. Many have been coming to PPNYC for years; many are referred by mothers, sisters, and friends who have used the HUB's services before. The HUB is a trusted community resource, not only for health services but for educational

programs and teen pregnancy programs as well. Even if there were other services to which these families, women, and teens could turn, there is no doubt that many would be lost in the transition. And, in the South Bronx, adequate alternatives simply do not exist.

12. The alternatives to the HUB clinic are Montefiore Family Care, Soundview Family Care, and The Martin Luther King Center, all smaller community health centers, and the Bronx municipal hospitals. Together the three small centers are not capable of absorbing PPNYC's client load; nor do they have PPNYC's commitment or expertise. The local municipal hospitals, Lincoln, Bronx Lebanon, North Central Bronx, and Bronx Municipal, are already overcrowded to the point of dysfunction.

13. Planned Parenthood of New York City's programs in the South Bronx are utilized by the community because they are of the highest quality. The program was comprehensively evaluated in 1986 and again in 1989 by a team of professionals from the Department of Health and Human Services. The site team's original report concluded: "The HUB program is an impressive program conceptually and is dynamic, well organized and implemented by a sensitive and caring staff." In 1989, most comments centered on how the HUB had become even more effective. The site team made clear in its exit interview that this is what a Title X program is supposed to be. Among the site team's comments in their written report in 1989:

ADMINISTRATIVE FINDINGS

"The agency is organized and well run."

"Excellent training programs are provided for staff and volunteers."

CLINICAL MANAGEMENT

"Since the last Title X Family Planning Program visit by the clinical reviewer in April 1986, the HUB has continued to improve their health services to their patients."

"The physical facility still impresses the visitor with its bright, clean and comfortable appearance."

COMMUNITY OUTREACH & EDUCATION

"An effective array of linkages has been established with a variety of organizations and programs in New York with whom the agency can refer for services, accept referrals from and present programs."

"A major ingredient which increases the effectiveness of what is essentially a small staff is the integrated manner in which program staff work together. The social service staff is an example of this. With a small staff, the influence of the program is felt across most program areas."

14. No other organization--if suddenly given the Title X grant monies that have supported the development of the HUB's clinic and outreach activities for many years--could replace a totally integrated program of such depth, effectiveness, and community acceptance. Indeed, it would require a start-up period of

at least 6 months to 1 year in order to provide minimum services. Programs of substance and quality are not built in one or even two years. It is not hard to imagine what would happen to the thousands of people served by PPNYC in the South Bronx. Many, if not most, would be lost in the shuffle--without services during the hiatus and at increased risk of unintended pregnancy, infection with the AIDS virus, sexually transmitted diseases, and low-birth weight babies.

WHEREFORE, I respectfully request that the court grant Plaintiffs-Appellants' Motion for Stay and Injunction Pending Review on Writ of Certiorari.

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on:
November 10, 1989

/s/
JOAN COOMBS

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE STATE OF NEW YORK, ET AL.,

Plaintiffs-Appellants,

- against -

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Defendant-Appellee.

AFFIDAVIT

STATE OF NEW YORK)
:SS
COUNTY OF SCHENECTADY)

PAUL DRISGULA, being duly sworn, deposes and says:

1. I am Director of Planned Parenthood of Schenectady and Affiliated Counties ("PPSAC"). I make this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. I have held my current position since 1982 and in this capacity, am familiar with the services provided by this agency and of the needs of our patients. Prior to my

current position, I was Director of Planned Parenthood of Northern New York. Based on my experience, I believe the current regulations would have a devastating impact on our continued ability to provide needed and vital family planning services to our clients.

A. PPSAC's Organization, Funding and Clients.

3. PPSAC serves five counties: Schenectady, Schoharie, Fulton, Hamilton and Montgomery. We have centers in Schenectady, Fulton, Schoharie and Hamilton.

4. In 1986, our total income was $1,502,600, thirty percent of which was from Federal and State funds. We received $73,407 in Title X monies and a total of $356,821 in combined monies from New York State local assistance and Title V, Maternal and Child Health ("MCH") monies. Medicaid family planning monies constituted approximately 9% of our income.

5. The four centers and headquarters of PPSAC currently have a total of 25 full time staff, and approximately 53 paid part-time staff. Positions include nurse practitioners, physicians, counselors, nurses, educators, administrators and support staff. During 1986, 90 trained volunteers provided an in-kind contribution of 5,946 hours, valued at $45,000, operating our rape crisis hotline for 8,760 hours. See para. 16, infra.

6. PPSAC provides comprehensive family planning services that include: reproductive health examinations; contraceptive services; counseling and referrals and community education; teen pregnancy programs and a rape crisis service. In addition, the Schenectady Center provides surgical services including first and second early trimester abortions.

7. In 1986, PPSAC served a total of 8,463 women, 24% of our patients were aged 18-19; 23% were under age 17. 84% of our patients receive subsidized care and fall 100-150% below poverty level.

B. SERVICES CURRENTLY PROVIDED BY PPSAC.

8. Many of our patients -- particularly our young patients -- come to PPSAC because they suspect they are pregnant. From July 1986 to June 1987, PPSAC performed 2930 pregnancy tests. When a patient tests positive, the counselor discusses the patient's feelings with her, all the options available to her, her family situation, including parental involvement (if appropriate), her financial status and future use of birth control. The counselor attempts to elicit and convey information in an honest, informative and non-judgmental manner to enable the patient to freely choose the option best suited for her. 55% of the patients diagnosed tested positive.

9. Patients receive at least three referrals for any service, including abortion. Among the referral sheets we distribute are lists of mental health counselors and therapists; ultrasound referrals; ob/gyn health care providers; prenatal referrals; nutrition/weight loss/weight control experts; urologists; surgeons; internists, family practitioners; fertility testing specialists; and abortion referrals. The information on each list includes the fees charged, the waiting time for an appointment and other relevant information, depending on the nature of the referral. Abortion referral information may include information regarding the distance to the abortion provider. We also distribute a brochure on adoption.

10. Between July 1, 1986 and June 30, 1987, 70%

of the patients who tested positive -- or 1119 patients -- were referred for abortion. In 1986, a total of 1253 patients were referred for abortion. Patients selecting abortion are given a fact sheet about early abortion, or mid-trimester abortion, depending on the situation. The sheets describe what abortion is, how it is performed, and possible medical problems that the patient may experience.

11. From July of 1986 through June of 1987, 885 of the patients chose abortion services at our Schenectady Center. 16% of these patients were under 18 years old. 234 chose abortion services elsewhere, or because of medical contraindications, were referred to other facilities. 16% of these patients were under 18 years old.

12. From July of 1986 through June of 1987, 336 patients chose prenatal care. Nine patients were interested in surrendering their babies for adoption. As part of our counseling, we provide brochures and information on prenatal care and postpartum care. We also distribute information on social services that are available to our patients. For example, we distribute information regarding the WIC program, which is a special supplemental food program for women, infants and children that is administered by the United States Department of Agriculture through the New York State Department of Health.

13. From July of 1986 through June of 1987, we received 1798 phone calls from women referred to us for abortion services. Of those, 1353 were scheduled for abortions [at] our Schenectady Center and 445 were referred to other abortion providers. Additional phone referrals we provided were: 68 women were referred for prenatal care; 7 women were referred to adoption

agencies; 138 people were referred to community agencies; and 48 men and women were referred for sterilization procedures.

14. Patients that are referred are asked to complete a confidential consumer feedback information form. This form is extremely beneficial in ensuring that our patients are referred to high quality providers. PPSAC regularly inspects the facilities to which patients are referred, utilizing private contributions and patient fees to evaluate the facilities.

15. Educational programs are an important facet of PPSAC's work. Our education programs include speakers, audio visual programs and printed resource materials. We also maintain a resource center. PPSAC provides training and education to many community professionals in the fields of health, social services and education. We also run human sexuality programs to a wide variety of groups including community, religious and educational facilities. Recognizing the sensitive and complex nature of the issues addressed in our programs, our educators attempt to provide their audience with current complete, accurate and non-judgmental information. Efforts are made to facilitate discussion and audience participation is encouraged. We attempt to address questions with precise information which will assist the questioner. Most importantly, we don't skirt the tough issues or avoid areas that are controversial. Abortion is regularly discussed, not as a method of family planning, but as a means of terminating an unintended or risky pregnancy. Because of our candid and informational approach, our education programs are well attended. Indeed, in 1986, 290 groups attended our programs, with a total number of 6183 people in attendance at these programs.

16. Teen pregnancy is a particularly acute problem because of the increased health risks to mother and child and the adverse social consequences of teen childbearing. Accordingly, PPSAC participates in and coordinates a variety of programs for teens to address the special family planning issues related to teens. For example, PPSAC participated in two multi-agency efforts to prevent teenage pregnancy and to help pregnant teens stay in school or develop vocational skills. These programs involve encouraging teens to use available community services and facilitating teen participation in those programs. We also work with the YWCA in Schenectady, which has a program for pregnant teens and young mothers.

17. PPSAC also runs a rape crisis service for the counties we serve. Our services include a 24-hour hotline, free counseling and support for legal, medical and emotional concerns of rape victims. As part of this service, rape victims may be provided with information regarding abortion-related services.

C. EFFECT OF THE CURRENT REGULATIONS.

18. As discussed above, PPSAC serves a clientele comprised mainly of low-income people who have no other family planning providers or other medical providers to which to turn.

19. Many of our clients visit PPSAC as a result of a pregnancy scare. Many, however, continue to rely on PPSAC as their medical provider irrespective of the outcome of their pregnancy test because they feel comfortable in our environment and confident of the quality of our services. Because of the full range of honest, professional and high quality services provided,

PPSAC is viewed as a source of information and help. The new regulations will make it impossible for us to maintain this reputation because they limit our ability to provide comprehensive services, counseling and referrals. Consequently, many patients who are now provided with testing for sexually transmitted diseases, with contraceptives, and with routine gynecological examinations will not benefit from those services. Others, who are now referred to other medical providers because of medical ailments detected by PPSAC, will remain untreated.

20. The regulations restrict us from providing necessary and appropriate counseling to a woman diagnosed as pregnant. Instead of assisting the woman in exercising her right to choose the option best for her, we would be limited to referring the woman to prenatal services. We could not advise the woman that she could obtain an abortion, nor could we provide her with information explaining the abortion procedure. Many of our patients are unaware that abortion is an option available to them, and thus, will be unable to make an informed choice.

21. The regulations compel us to tell a woman who inquires about abortion that we don't give referrals for abortion. The regulations therefore force us to indicate disapproval of abortion, although it is a safe and legal option. We will be placed in making the choice for the woman, instead of assisting her in making her own choice.

22. We will be barred from providing our descriptive and comprehensive fact sheets and referral sheets. Without this information, many of our patients will travel needlessly long distances to obtain services or

will contact providers who do not accept Medicaid. As a result, many of our patients may delay or encounter delays in obtaining abortions. Given that health risks increase if a patient receives an abortion after her first trimester, these delays may needlessly result in the health risks to our patients.

23. It is particularly shocking that in cases where pregnancy might enhance an illness, the regulations preclude us from referring a patient for an abortion or even telling the woman that she or the child, is at risk if she continues the pregnancy. This prohibition is unconscionable and will expose our agency and health professionals to potential malpractice liability.

24. Tragically, in 1986, 15 of our patients became pregnant as a result of rape. The regulations would prohibit us from advising these women of the availability of abortions. Similarly, our hot-line operators would be prohibited from telling victims that if they become pregnant, they can terminate the pregnancy. This knowledge assists some victims in regaining a sense of dignity and balance that is very difficult to achieve after the violent, degrading experience of rape.

25. The regulations would force us to discontinue providing services with our Title V funds, such as counseling on prenatal care and nutrition. We would be permitted to continue these services only by separating the facilities that provide pre-pregnancy services from prenatal care services. This is not only financially unfeasible, but would disrupt the continuity in care currently provided and from which our clients benefit.

26. We would also be forced to impose counseling promoting the health of the fetus to the woman who has

elected abortion, until the time of the referral appointment. Promoting childbirth in this situation is particularly inappropriate.

27. Separating the abortion services from the Title X funded services as required under the regulations would be prohibitively costly. Acquiring a facility and renovating it to make it acceptable for our needs and compliant with State and local codes would be an extremely expensive proposition. In 1979, we renovated an unused part of our existing building for surgical use. That renovation alone cost $82,000. Even assuming we could use some of our equipment in a new site, we would need to acquire a building which would probably cost between $75,000 and $100,000 for the building and additional costs for ample parking space. It would be unfeasible for PPSAC to shoulder these costs, together with the costs for inventory, equipment, furniture and duplication of staff with our full range of benefits.

28. If PPSAC ceased providing abortions and abortion-related services, the clients we serve would suffer. As set forth above, a large percentage of the patients diagnosed as pregnant by PPSAC and other providers rely on PPSAC for safe, high quality inexpensive abortion services. Indeed, there are no other local physicians that will accept Medicaid for abortion services. The only other local Medicaid providers that perform abortions are Ellis Hospital and Albany Medical Center. Both these hospitals, however, charge between $100 and $1000 more for an abortion than does PPSAC. In addition, as opposed to PPSAC's waiting time of between two to seven days, each has a waiting period of two to three weeks. Physicians and hospitals which do not accept Medicaid would be prohibitively expensive for our clients.

29. The extreme harm that our patients would suffer if we ceased providing abortion services is exacerbated because we provide services in a rural area to a rural population. Travel is difficult for many Medicaid patients. There is little transportation from many rural areas and the cost of transportation is prohibitive even if it is available. Many people receiving public assistance do not have cars or friends with cars that are able to travel any distance. Money for travel includes gas, tolls, meals, and child care. There are frequently no people to borrow from or help in any way. Many people also fear cities. Patients coming from a distance such as Utica on the bus frequently come alone as their friends are either providing childcare[,] money[,] or both. There can be bus delays in either direction, even worse, if the bus home is missed, there may be no money to spend the night out of town.

30. The regulations will also interfere with our ability to continue our educational programs from which our community benefits. The regulations would make discussion of abortion off-limits. This would be a real loss to our community since the availability of information on issues related to sexuality [and] reproductive health is limited. Absent an atmosphere of free discussion and free inquiry, attendance will wane.

30. As Director, I foresee that the regulations will jeopardize our ability to continue to attract outstanding health professionals and staff because they will not only be forced to breach their professional ethics by not providing necessary and appropriate options counseling but will also be exposed to potential liability.

D. CONCLUSION.

31. For the reasons set forth above, I respectfully submit that this Court should grant the relief requested in plaintiffs' motion.

/s/
PAUL DRISGULA

Sworn to before me this
14th day of December, 1987.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	**DECLARATION**
	:	88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

RAYMOND FINK deposes and says the following:

1. I am the Chairperson of the Medical and Health Research Association of New York City, Inc. (MHRA). As MHRA's Chairperson, I preside over its Board of Directors in establishing policy and directions for its provision of maternal and infant care, youth services and family planning and reproductive health care to the greater metropolitan population. A copy of my resume is attached hereto as Exhibit A.

2. I submit this declaration in support of plaintiffs' Motion for a Preliminary Injunction enjoining implementation of proposed regulations promulgated under Title X of the Public Health Services Act (Title X). I also submit this declaration in support of plaintiffs' request for an early hearing date. This declaration is

submitted in my official capacity as Chairperson of MHRA and in my professional capacity as an expert in community and preventive medicine.

3. The Medical and Health Research Association of New York City, Inc. has been a direct grantee of Title X Family Planning Funds since 1982. MHRA has 600 employees and its service divisions provided care to 42,000 pregnant women, infants, children, adolescents and their families in 1986 alone. The vast majority of these individuals were Black or Hispanic and over 90% had incomes at or below 150% of the federal poverty level. MHRA service projects are targeted to the low income-high risk population of New York City and approximately 60% of those served have no insurance and are thus, entirely dependent on the availability of high quality, low cost, community based health services such as those provided by MHRA and its subgrantees. For many of the individuals served by MHRA, Title X and like sources of funding permit them to enter into a health care system from which they might otherwise be barred by indigency and other factors.

4. In 1987, for example, MHRA received $2,104,950 in Title X funds from the U.S. Department of Health and Human Services (HHS) of which $430,549 was subgranted to plaintiff Planned Parenthood of New York City, Inc., $480,247 to Columbia Presbyterian Hospital, $466,241 to The Door (an innovative community based adolescent care program) and $668,076 was used by MHRA to provide covered services through its own service division, the Maternity, Infant Care -- Family Planning Projects ["MIC-FPP"]. MIC-FPP has been in operation since 1964 and has been administered

by MHRA since 1975.*

5. MIC-FPP receives funds from both the New York City and New York State Departments of Health, from the HHS and from some private sources. Federal monies include Title X funds for family planning, Title V funds under the Maternal-Child Health Block Grants, and Title XIX Medicaid reimbursement.

6. MIC-FPP is the largest maternal and infant care program in the nation. The prenatal patients we serve give birth to approximately 9,000 babies a year. Approximately 25% of these mothers are age 19 or under.

7. With a combination of funds under Titles V, X and XIX, MIC-FPP provides family planning services to approximately 20,000 clinic patients a year, 26% of whom are age 19 or under. With Title X funds it also provides counseling services in hospitals[,] schools and the community to 27,000 individuals, about 45% of whom are age 19 or under. Title X constitutes 5% of MIC-FPP's total budget.

8. MIC-FPP presently operates ten clinics. One of these clinics, the Tremont Clinic, receives Title X funds under the Public Health Service Act, as well as Title V funds. Many employees at Tremont are funded under both Titles X and V.

9. The Tremont Clinic provides prenatal care to approximately 1,200 patients per year; gives over 200 pregnancy tests to individuals who are not otherwise

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* $42,446 for Addabbo/PRYME Community Health Center and $17,391 for MHRA Administration of the grant.

registered patients; and offers family planning to approximately 2,400 patients in 4,700 visits per year. The clinic does not perform abortions. Consistent with the most recent Title X guidelines, however, clinic staff provide counseling and referral for abortion where indicated or requested. Referrals for abortion are made to one of fourteen back-up hospitals. Prenatal patients at Tremont receive amniocentesis and genetic testing referrals as well as follow-up counseling by clinic staff on the premises. Counseling in this context often involves a discussion of pregnancy termination as a treatment option in the event of adverse test results.

10. In addition to MIC-FPP's Tremont Clinic, it operates three community education programs which receive Title X funds:

(a) The In-Hospital Family Planning Program provides individualized family planning counseling to postpartum women before they leave the hospital. MIC-FPP family planning counselors are assigned to the obstetric/gynecologic in-patient units of affiliated hospitals. The counselor's function is to educate women on the advantages of planned pregnancy and to counsel on the available methods of family planning. Counselors also discuss well-baby care with mothers and help them select a source of pediatric care.

(b) The Teen Reach Program was established in 1978 to help prevent unwanted pregnancies among high school students and to help the students get family planning and health related services. MIC-FPP assigns health educators to each participating school. Their responsibilities include conducting classroom presentations and small group sessions, and providing individual counseling and referrals for teens in need of

health services.

(c) The Askable Parent Program provides parents with information so that they can provide sex education to their children. The Program targets parents in districts of New York City with the highest incidence of adolescent pregnancy. The Program is carried out by trained volunteer parent-leaders who conduct workshops with parents. The emphasis of the Program is on enhancing communication skills between parent and child.

11. The services which are offered by MHRA, its service divisions and subgrantees are uniformly accessible, effective, of high quality and in full compliance with current Title X guidelines and regulations.

12. I have studied the new regulations. In my professional opinion, and in the opinion of MHRA, these regulations will destroy our ability to provide high quality and effective services in accordance with ethical and legal norms designed to protect the health and dignity of our patients. The following are examples of how our clients and staff will be irreparably harmed should these regulations be implemented:

(a) MHRA will be unable to provide patients who cannot afford private medical care with the same treatment and information routinely provided by our physicians to their private patients.

(b) Our Title X-funded health care staff will be prevented from making medically sound referrals. The proposed regulations will compel physicians to: jeopardize the health and safety of patients; go against

New York State Article 28 requirements that all patients be informed of all available medical options; and disregard accepted medical and ethical standards of practice as promulgated by the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Psychological Association among others.

(c) Our providers will be unable to respond appropriately to all inquiries by their patients although the freedom to do so is central to success in preventing unintended pregnancy. They will also be unable to emphasize in a meaningful manner, the importance of family planning and responsible sexual behavior to patients because to do so requires discussion of the success and failure rates of all contraceptive modalities and how these affect one's ability to avoid unintended pregnancy and unwanted childbirth.

(d) The new regulations restrict the ability of family planning personnel to provide medically ethical, comprehensive health care services and information even in cases where, although no "emergency" exists, a patient's health is in serious danger, thus inviting negligence and malpractice suits against family planning facilities and the physicians they employ. This will render Title X programs unable to attract and retain competent, high-caliber health care professionals. This, in turn, will be detrimental to our ability to serve patients responsively and effectively.

(e) The new regulations require that pregnant and non-pregnant women with otherwise similar medical problems be given radically different medical care and referral plans, since in the absence of an emergency, after a pregnancy is diagnosed, a patient may only

receive a prenatal referral, even if the medical problem is unrelated to the pregnancy. For example, while we might make an appropriate referral for a non-pregnant woman with a breast lump, we would be required to make an inappropriate referral of a pregnant woman with a breast lump to a prenatal service. To respond to any medical problem based solely on a patient's pregnancy status would be entirely inconsistent with sound ethical medical practice and could endanger the health and/or life of the patient.

(f) The regulations mandate that pregnant patients receive a biased referral list which may be inappropriate and unresponsive to the medical and psychological needs and circumstances of the patient. This may hinder the patient's own efforts to obtain appropriate, timely, medical care or abortion services.

(g) The regulations further require that Title X health care professionals give every pregnant patient information on prenatal care, thus affirmatively steering them toward the option of childbirth. This mandatory push in the direction of carrying to term may increase the rate of unwanted childbirth.

13. The separation requirements mandated by regulation 59.9 may effectively serve to shut down a considerable number of clinics that now receive Title X funds, by making it impossible for them to continue accepting funding. The loss of their services to the thousands of low-income women and teenagers now receiving them, can only result in greater numbers of unintended pregnancies and consequent abortions. Regulation 59.9 will have particularly deleterious effects on providers such as the Tremont Clinic which also provide comprehensive health services with non-Title X

funds. In our opinion, the effect of this section will be to:

(a) Create criteria for compliance which will in many cases be prohibitively expensive and operationally untenable. Clinics with comprehensive reproductive health services and even large metropolitan hospitals cannot provide for the degree of separation called for by §59.9. Many, if not most of such facilities have deliberately attempted to integrate services which are substantively related in the interest of efficiency and the overall convenience of staff and patients. Contrary to the implication of this proposed regulation, th[e] trend is toward compliance with this Title X's requirement of coordinated services and the maximization of limited financial resources; it is <u>not</u> a means of railroading pregnant women into the abortion choice.

(b) Affect the completeness of a patient's medical record at Title X-funded clinics, thereby having a negative impact on the quality of medical care which can be provided. Health care providers will have to keep separate medical histories and patient records for Title X family planning services and abortion or abortion-related services. A single patient may have two or even three separate charts. Thus, the health professional in a Title X-funded program will routinely be forced to reach decisions regarding the provision of family planning treatment based on what may be an incomplete medical history. This could result in the prescription of an inappropriate contraceptive modality which places the patient at risk of an unintended pregnancy or of some other harm.

(c) Disqualify Title X-funded programs which are located in facilities which provide, with non-Title X

funds, comprehensive maternity services and discuss the option of pregnancy termination in the context of providing routine genetics counseling or amniocentesis test results for the express purpose of permitting patients to prevent the birth of an infant with some genetic disability.

14. Finally, new regulation 59.10 will bar organizations receiving Title X funds from freely associating with advocacy or other groups of their choice, and could prevent those organizations from obtaining appropriate legal recourse in lawsuits seeking to ensure access to abortion-related information and services. It further precludes any non-pejorative mention of abortion or of medical indication for abortion, construing such speech as "advocacy" in contravention of the Title X statute. This prohibition seems to apply even to our use of non-Title X funds.

15. The Medical and Health Research Association is categorically opposed to the proposed regulations. In the interest of extricating preventive family planning services from a postulated "entanglement" with abortion and related services which does not in fact exist, HHS risks dismantling the Title X program and all it has accomplished.

16. The new regulations condition the receipt of much needed government funds on our agreement to waive constitutional rights and to act against the best interests of the patients we serve. Moreover, our health care staff is precluded from living up to the trust they rightfully cultivate in their patients. Patients and physicians in Title X-funded programs will be unable to communicate forthrightly and patients will thus be misguided, delayed or led to make dangerous or ill-

advised health care decisions.

17. These regulations will require that our medical and health personnel distort their professional judgment and withhold information from patients regarding their legal options and health risks. This is unethical. Moreover, it would subject us to malpractice exposure, severely curtailing our service delivery capacity.

18. For all these reasons, MHRA, on behalf of its service divisions, its delegate agencies, its staff, and the patients it serves, will be irreparably harmed if the regulations are not immediately enjoined.

WHEREFORE, I respectfully request that the Court grant plaintiffs' Motion for a Preliminary Injunction.

I declare under penalty of perjury, that the foregoing is true.

Executed on: 3 February 1988 /s/
RAYMOND FINK, Ph.D.

[Exhibit omitted.]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE STATE OF NEW YORK, ET AL.,	:	
Plaintiffs-Appellants,	:	AFFIDAVIT
- against -	:	
DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,	:	88 Civ. 0701 (Stanton, J.)
Defendant-Appellee.	:	

Dr. Melita Gesche, being duly sworn, deposes and says:

1. I am Director of the Bureau of Reproductive Health of the New York State Department of Health ("NYSDOH") and have managed the Department's family planning program since 1969. I am also a physician duly licensed to practice medicine in New York State and I am board certified in preventive medicine. I submit this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. The New York State Department of Health is vested with the responsibility of protecting and furthering the health and well-being of New York State's residents. (New York Public Health Law, subsections 201, 206).

Assessing and addressing the state-wide need for appropriate, effective family planning is an integral and important part of the NYSDOH's legislative mandate to oversee and ensure the provision of health services in New York State.

3. As I will discuss in detail below, and as was set forth in NYSDOH Commissioner David Axelrod's comments on the proposed regulations, included in the joint appendix at page 165A, the challenged Title X regulations pose a severe and far-reaching threat to the health and safety of New York State's residents who utilize the services of Title X supported providers, are inconsistent with well-accepted standards of medical care and New York State law and will have a disastrous effect on the provision of family planning services in New York State. In addition, the regulations will have grave financial and administrative consequences for New York State.

A. Overview of the State's Family Planning Services

1. The NYSDOH's Title X Grant

4. The NYSDOH, through its Bureau of Reproductive Health, is one of two Title X grantees in New York State. The other is the Medical Health and Research Association of New York City, Inc. ("MHRA"). As a grantee, the NYSDOH administers the yearly Title X family planning services project grant it receives from the United States Department of Health and Human Services ("HHS"). In 1987-88, the NYSDOH's Title X grant was $5,925,177.

5. The NYSDOH reviews applications from the family planning agencies currently subsidized by the

above HHS Title X grant seeking renewal of their Title X grants (virtually all of whom, also receive State grant funds). The NYSDOH Title X project grant funds 37 delegate agencies throughout New York State. The delegate agencies include hospitals, Planned Parenthood affiliates, community health centers, county health departments and other agencies. A list of those delegate agencies and the respective counties they serve is annexed hereto as Exhibit A.

6. Nearly 200,000 women were served by Title X subsidized family planning delegate agencies in 1986. Exhibit B annexed hereto contains data reflecting the number of women who utilized Title X subsidized agencies for the last three years. During that same time period, more than 75% of the patients seen in Title X subsidized projects were at or below 150% of the Federal poverty level. In 1986, for example, 79.5% of the women served by Title X subsidized projects were at or below 150% of the Federal poverty level.

7. In 1986, 70,000 adolescents in New York State used the services of agencies who were funded, in part, by Title X monies. Annexed as Exhibit C is a chart reflecting the total number of adolescents who have used the services of Title X delegate agencies in the last three years.

8. In administering this Title X grant, the NYSDOH is required to adhere to applicable federal law, regulations and guidelines. To ensure compliance, the NYSDOH frequently consults with the regional office of HHS. The "Program Guidelines For Project Grants For Family Planning Services" issued by the Bureau of Community Health Services ("BCHS") that have been operative and with which NYSDOH has complied are

part of [the Second Circuit] joint appendix at page 24A. The NYSDOH is "held responsible for the quality, cost, accessibility, reporting and performance of its delegate agencies." See Joint Appendix, page 28A § 6.1. Title X funding is contingent upon compliance with federal regulations and guidelines.

9. The NYSDOH has divided New York State into six health regions. Each region has one family planning nurse who provides ongoing monitoring and technical assistance to the delegate agencies in that nurse's region. In addition, the NYSDOH monitors and assesses the family planning needs in the state and works with the delegate agencies to ensure that those needs are addressed. An advisory committee, composed of Title X subsidized delegate agencies and other providers of family planning services in New York State meets informally on a regular basis to study and discuss policy and programmatic issues related to the provision of family planning services.

2. Other Funding For Family Planning Services In New York State

10. Annexed hereto as Exhibit D is a chart reflecting the decreased levels of funding of the Title X program in New York State from 1978 to 1988. In 1978-79, total funding of all then New York State grantees was $9,339,368; for 1987-88, the current program year, total funding is $8,027,967. Title X funding has not been adjusted for inflation, nor for the growing need for family planning services. Although the NYSDOH now receives more Title X monies than it did in the past, that is the result of the consolidation of other project grants; i.e., there are fewer direct grantees now than in the past. Indeed, the entire New York State's 87-88 grant is 21.5%

below the funding level received in 1980-81.

11. As reflected in Exhibit D, state funding has replaced Title X as the major source of monies for family planning services. State local assistance for the 1987-1988 calendar year was $11,150,000. Other state subsidized funding includes direct aid to localities when applicable and Medicaid. The state's funding of family planning services is consistent with its obligation and commitment to provide comprehensive health services to its residents and its recognition of the critical need for family planning services throughout the state.

12. The NYSDOH also receives a grant under the Maternal and Child Health Services ("MCH") Block Grant, Title V of the Social Security Act, 42 U.S.C. § 701. Exhibit D shows the amount of dollars ($1,368,888) from the 1987-88 MCH Block Grant that the NYSDOH uses directly for family planning services. The purpose of this grant, which is distributed by the NYSDOH to agencies throughout the State, is to promote the health of mothers and children. In furtherance of Title V's objectives, services recipients of MCH Block funds may provide genetic counseling and amniocentesis.

B. Impact of the Regulations on New York State

1. The Health Threat to Women Served by Title X Funded Agencies

13. Because they ignore basic principles of sound medical practice, the new regulations pose a serious and immediate threat to the health and safety of the nearly 200,000 women in New York State currently served by Title X subsidized agencies.

14. Because of the regulations' restrictive definition of permissible family planning services, the Title X counselor is essentially proscribed from counseling a patient once that patient is diagnosed as pregnant. Hence, the regulations force the provider to cease providing services to the pregnant client without addressing the medical, social and educational needs of that client. This prohibition is contrary to accepted standards of medical practice which recognize the necessity of continuity of care, and would affect services the provider would render even with state funds.

15. Further, the regulations would bar the Title X agency from providing the pregnant patient with complete and comprehensive information regarding the full range of options available to her. The Title X subsidized agency would not be able to refer or counsel the patient regarding all her options nor provide the patient with descriptive information to aid her in making a decision. Instead of providing the patient with appropriate or necessary counseling, the Title X subsidized agency would be restricted to handing the patient a list of names weighted in favor of health care providers who provide prenatal care. This again patently violates all tenets of sound and ethical, medical practice, which, as codified in the State's public health law on informed consent, require health professionals to disclose to patients all risks, benefits and alternatives to a particular mode of treatment. Public Health Law §2805-d.

16. The bar against counseling a pregnant woman is so extreme that it applies even where the woman's health is at risk. A pregnant woman suffering from cancer, AIDS, or diabetes cannot receive counseling regarding the risks if she continues the pregnancy. The Title X subsidized provider is permitted only to refer the ill

patient to a specialist, which may result in delay injurious to the woman's health. In these situations, the denial of necessary information is particularly injurious.

17. In November of 1987, the NYSDOH began a statewide study to assess the rate of HIV infection in the population. Preliminary results from testing of blood samples from infants indicates an alarming HIV infection rate among women of childbearing age in New York State, particularly in New York City. Projections based on the early results of these tests indicate that more than 2,300 HIV infected women will give birth and an estimated 1,000 infected infants will be born in New York State in 1988. The NYSDOH is notifying physicians and family planning providers of these preliminary findings and urging them to counsel women regarding the risk of HIV infection. Copies of the letter sent to health care providers and the preliminary findings are annexed hereto as Exhibits E and F. A copy of a letter sent to family planning providers in New York State, annexed hereto as Exhibit G, similarly emphasizes the State's concern about HIV transmission. The NYSDOH is requiring that state subsidized family planning providers offer HIV counseling and testing. The new regulations will bar appropriate options counseling to HIV infected women, whose risk of developing full blown AIDS may be enhanced by the pregnancy.

18. The separation requirements contained in 42 C.F.R. § 59.9 threaten the continued viability of many of the Title X subsidized agencies in New York because of the administrative costs, increased costs for property and property insurance, increased costs of personnel and the like. Most hard hit will be rural areas, in which the Title X subsidized clinics serve large areas and where

duplication of services would be financially and administratively unfeasible. Consequently, the regulations jeopardize the availability of family planning services to women in New York State, particularly in its rural areas.

2. Impact on Adolescents

19. The regulations pose an acute threat to the health and well-being of the State's nearly 70,000 adolescents served by Title X subsidized agencies, the vast majority of whom are poor. Nowhere is the need for comprehensive family planning services greater than with adolescents. The health dangers posed by the new regulations are even greater in the context of teens who are physically and emotionally fragile, largely uneducated and without other available resources.

20. The adverse medical and social consequences of teenage childbearing require increased family planning services for adolescents. As described in a recent study by the Centers for Disease Control, annexed hereto as Exhibit H, New York State witnessed a 27.5% reduction in pregnancy rates in sexually experienced teens aged 15-19 between 1974-1980. This was the highest rate of decrease in the country of the states surveyed. Nonetheless, as reflected in Exhibits I and J, urban areas in New York State experienced a rise in pregnancy rates for this period. By limiting the information available to teens who rely on Title X subsidized agencies and by making it impossible for Title X subsidized agencies to provide comprehensive services, the regulations will have a deleterious effect on teenage pregnancy and teenage health.

3. Financial Impact of the Regulations

21. Implementation of the regulations would further drain the limited resources of the state, which already largely fund the family planning programs in New York State. Because the regulations conflict with state law and with well settled standards of professional conduct see paragraph 15, ante, agencies would be forced to choose between State and Title X funding. Replacing Title X funds will indeed be costly to the state. Even if the state law provisions explained in paragraph 15 could be ignored and agencies could receive both federal and state funding, the regulations would still increase costs of the state. For example, the regulations' separation requirements would prove so financially and administratively burdensome for many Title X recipients that they may choose either not to comply with those requirements or to provide only restricted services under Title X. Either choice will impose a financial burden on the state which may have to replace either the abandoned money or service.

22. Similarly, agencies which receive Title X funds and MCH Block Grant and state monies, see paragraphs 11, 12, ante, would have to choose between those two types of funding. MCH Block funds are to be used for prenatal, postpartum and delivery services. Under the new regulations, however, Title X recipients would not be able to provide postpartum services at the Title X subsidized clinic. Nor would the agency be able to engage in MCH Block prenatal services such as genetic counseling or amniocentesis, which may result in counseling involving options, or participate in the state funded new prenatal care initiative intended to decrease infant mortality.

23. The State would also be financially and administratively burdened by the new regulations as a result of their effect on the state's Certificate of Need ("CON") process. (N.Y. Public Health Law § 2802). Separation of family planning services from post-partum counseling would require an application under the New York CON process. While the process can be expedited to reduce dislocation and cessation of services, it can be expected to result in some interruption of services. Separate service entities would certainly lead to duplication of costs.

C. Conclusion

25. For the reasons set forth above, I respectfully submit that the requlations will have a devastating impact on the family planning program in New York State.

/s/
Dr. Melita C. Gesche

Sworn to before me this
10th day of November, 1987

[Exhibits omitted.]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE STATE OF NEW YORK, ET AL.,
Plaintiffs,
- against -
OTIS R. BOWEN, et al.,
Defendant.

AFFIDAVIT
88-Civ-0701 (LLS)

DR. IRVING RUST, ET AL.,
Plaintiffs,
- against -
OTIS R. BOWEN, ET AL.,
Defendant.

AFFIDAVIT
88-Civ-0702 (LLS)

STATE OF NEW YORK)
: SS:
COUNTY OF ALBANY)

SHIRLEY GORDON, being duly sworn, deposes and says:

1. I am Executive Director of Family Planning Advocates of New York State, Inc. ("FPA"), a non-profit corporation formed in 1977 to lobby on behalf of

consumers and family planning agencies in New York State regarding reproductive health care issues. FPA is a membership organization, composed [of] over 250 family planning clinics, health and human service providers, providers of reproductive health care as well as consumers. Our organization regularly conducts providers' surveys of to determine access to reproductive health care th[r]oughout the State.

2. I submit this affidavit in support of plaintiffs' cross-motion for summary judgment and in opposition to defendant's motion for summary judgment.

As FPA's Executive Director, I am familiar with the acute shortage of subsidized, low-cost family planning and abortion services in New York State. If implemented, the challenged regulations will effectively block many women's access to and exercise of their choice of abortion.

3. Section 59.8(a)(3) of the challenged regulations prohibits Title X clinics from including on the list of referral providers "health care providers whose principal business is the provision of abortions." By excluding from the list all providers who principally provide abortions, the Department of Health and Human Services is effectively excluding all abortion providers that poor women have access to and can afford. While the regulations allow hospitals and private physicians to be on the referral list, as explained below, neither are affordable or accessible to poor women, particularly those in upstate and rural New York.*

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* As used in this affidavit, the term "rural" applies to counties so designated by the New York State Rural Resources Commission.

4. The availability of abortion outside New York City is limited even for those women who are not poor.

5. Almost 40% of abortions throughout the State are performed outside New York City. The distribution of abortion services is markedly concentrated. 80% of those abortion, are performed in ten counties, four of which are actually part of the greater metropolitan area. Those counties are: Albany, Broome, Monroe, Erie, Onondaga, Oneida, Nassau, Suffolk, Westchester and Rockland.

6. According to 1986 statistics compiled by the New York State Department of Health ("Vital Statistics of New York State"), there were no abortions reported in thirteen rural counties. But residents in those counties, traveled beyond their home counties to obtain abortions. The shortage of abortion providers in rural and upstate New York and the effects of that shortage are most acutely felt by poor women, such as those served by Title X clinics. Many private physicians and hospitals simply do not or will not serve this population, or for the other reasons described below, are not accessible to poor women.

7. Particularly in upstate rural counties, cost is a major barrier to poor women obtaining abortions from private physicians and hospitals that do not have low out-patient services. In upstate and rural New York, the few hospitals that perform abortions may charge as much as $1400 for a first trimester abortion. Private physicians doing in-office procedures generally charge less than hospitals for the first trimester but are nonetheless prohibitively expensive for uninsured and underinsured women because a significant number do not accept Medicaid and virtually none offer [] services at a reduced

fee. Clinics, including those that are funded in part by Title X, accept Medicaid, and for people who are uninsured, will provide first-trimester abortions at substantially lower costs, accept Medicaid and fees are all generally inclusive of more than just the surgery. In general, first-trimester fees at such clinics range from $100-$300 in upstate New York.

8. Poor women and families that are either Medicaid ineligible, have not applied for Medicaid, or are waiting for benefits to be implemented (discussed below) are frequently otherwise uninsured. The fastest growing number of New York State's uninsured reside in its rural counties. Private health insurance is generally obtained through an employer. In rural New York State, as is the growing trend nationwide, heads of families, particularly single mothers, often work at jobs that offer no insurance at all. Teens are frequently uninsured; even when the head of the family is insured, that insurance does not cover dependents or the plan does not subsidize the cost of monthly premiums for family coverage. (And of course, many teens are effectively uninsured because they do not or cannot discuss pregnancy with their parents and cannot benefit from their parents' insurance). Without insurance, referral to a hospital or private doctor, would be of no benefit to the Title X patient seeking an abortion.

9. Women who are Medicaid eligible may nonetheless not be recipients. This is particularly true of young women who, until their pregnancy (or pregnancy scare) are not receiving any health services. The application process for Medicaid take[s] up to two months. Some poor women cannot negotiate the complicated process; others first apply when they become pregnant. A Medicaid eligible pregnant woman seeking

an abortion would therefore need a referral to a clinic she could afford and not a referral to a prohibitively expensive hospital or physician as could appear on the list. If the woman had to wait to become Medicaid eligible, before obtaining her abortion, her health risks would increase.

10. Private physicians frequently impose other restrictions on their provision of abortion services. Many, precisely because they do not "principally" provide abortions, do not accept new patients for abortions. Referrals to such physicians would thus be pointless. Many physicians have or impose other restrictions such as requiring parental or spousal consent before performing an abortion.

11. Few upstate private physicians will perform second trimester abortions, or in fact, even late first trimester abortions. Many perform abortions only up to ten weeks. Second trimester abortions, if performed, are even more expensive than first trimester abortions. The type of providers to whom referrals are barred under the regulations are more likely to perform late first-trimester and early second trimester abortions at lower rates.

12. In upstate and rural New York, distances between abortion providers are a further barrier to the ability of poor women to obtain abortions. Excluding abortion providers from the list (and effectively forcing Title X clinics to cease providing abortions under §59.9, as discussed below) means that women will not be aware of potential nearby providers and will travel longer distances than necessary to obtain an abortion. Delays in obtaining abortions will result in increased health risks to women. In addition, delay will result in potentially substantial increased costs. If the delay pushes the

patient to her second trimester, the cost of an abortion--if she can locate a provider--at that stage may cost between $700 and $1500. For example, Albany Medical Center charges as much as $1500 for an abortion in the twentieth week.

13. It is extremely difficult for poor women in upstate and rural New York to travel outside their counties to obtain abortions. St. Lawrence County for example, has no abortion services and no public transportation. In fact, very little of upstate and rural New York has public transportation and that which it has, is expensive. Traveling to providers therefore means finding a car, carfare, childcare, in many cases, overnight accommodations and missing work for a couple of days. For example, while a hospital might accept Medicaid, under New York's cost containment regulations, first trimester abortions must be ambulatory. Thus, the Medicaid eligible woman who travels several hours to a hospital must herself pay for overnight accommodations. This, of course, is expensive and cumbersome.

14. Hospitals and private physicians generally do not maintain the evening and Saturday hours of clinics that serve predominantly poor women and teenagers and recognize the special needs of that population. Hospitals and private physicians rarely schedule appointments on Saturdays or evenings to comport with schedules of workers, such as housekeepers, paid on a per diem basis who do not have the license or money to take days off of work. In addition, hospitals and private physicians generally have longer waiting periods for obtaining abortions.

15. In addition to other factors which make hospitals an improbable or inaccessible source of

abortions for poor women, problems related to confidentially and visibility are greater -- or perceived to be greater -- in the hospital setting. Women in small rural and upstate communities are reluctant to go to hospitals for abortions, fearing that they will be seen by neighbors or hospital staff. Referrals to clinics that principally provide abortions do not generate this fear or embarrassment.

16. Lack of confidentiality is also a problem for women who must travel to distant providers, as discussed above. Because the woman will be compelled to stay overnight, she will likely have disclose[d] to others her intent to obtain an abortion. For many women, especially teens, this disclosure is a problem. Again, limiting the referral list and excluding possible providers thus unnecessarily adds to this problem.

B. <u>The Effects of §59.9's "Program Integrity" Requirements</u>

17. As described, there is already a severe shortage of providers of abortion services in New York State. And, as discussed above, the shortage is most acute for poor women. To the extent that the regulations will cause Title X clinics to cease providing abortions with non-Title funds because of the costs involved in separating their facilities, the regulations will further limit the availability of affordable safe abortion to poor women and will make it more difficult--if not impossible--for women to exercise their right to choose abortion.

C. <u>The Overall Effect of These Regulations</u>

18. The more than 100 family planning clinics in New York State that are funded, in part, by Title X

funds provide otherwise unavailable health care services to poor women. The regulations will have a devastating impact on those clinics' ability to provide comprehensive services, including appropriate counseling and referrals.

Conclusion

For the reasons set forth above, I respectfully submit that plaintiffs' motion should be granted and defendants' motion should be denied.

/s/
SHIRLEY GORDON

Sworn to before me this
3rd day of February, 1988

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET Al.,	:	
Plaintiffs,	:	
- against -	:	DECLARATION
		88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

STANLEY K. HENSHAW, Ph.D., deposes and says the following:

1. I am Deputy Director of Research for the Alan Guttmacher Institute (AGI) in New York City. A copy of my resume is attached hereto as Exhibit A. AGI is an independent non-profit corporation involved in research, policy analysis and public education in the field of reproductive health care services. AGI collects original data on the delivery of family planning and abortion services in the United States. Reports on these subjects are published periodically. AGI statistics have, since 1975, been accepted by the Census Bureau as the most complete statistics on abortion in the United States, and are published each year in the Statistical Abstract of the United States. The United States Centers for Disease Control, which is part of the Department of Health and

Human Services, also publishes abortion statistics, but acknowledges that AGI's figures are more complete.

2. As Deputy Director of Research, I am responsible for overseeing a periodic survey of all abortion providers in the United States, including over 2,600 hospitals, free-standing clinics, and doctors who provide abortions in their offices. In this capacity I analyze and interpret demographic data relevant to this case. A list of some of my significant publications related to abortion and adolescents follows:

Henshaw, Binkin, Blaine and Smith, A Portrait of American Women Who Obtain Abortions, 17 Fam. Plan. Persp. 90-96 (1985).

Jones, Forrest, Goldman, Henshaw, Lincoln, Rosoff, Westoff and Wulf, Teenage Pregnancy in Developed Countries: Determinants and Policy Implications, 17 Fam. Plan. Persp. 53-63 (1985).

Henshaw, Forrest and Blaine, Abortion Services in the United States, 1981 and 1982, 16 Fam. Plan. Persp. 119-27 (1984).

Henshaw, ed., Abortion Services in the United States, Each State and Metropolitan Area, New York, N.Y. The Alan Guttmacher Institute (1983).

Henshaw and O'Reilly, Characteristics of Abortion Patients in the United States, 1979 and 1980,[] 15 Fam. Plan. Persp., 5-16 (1983).

Henshaw, Forrest, Sullivan and Tietze, Abortion Services in the United States, 1979 and 1980, 14 Fam. Plan. Persp. 5-15 (1982).

S. K. Henshaw, Forrest, Sullivan and Tietze, Abortion 1977-1979: Need and Services in the United States, Each State and Metropolitan Area, New York, N.Y. The Alan Guttmacher Institute (1981).

Forrest, Hermalin and Henshaw, The Impact of Family Planning Clinic Programs on Adolescent Pregnancy, 13 Fam. Plan. Persp. 109-116 (1981).

Henshaw, Forrest, Sullivan and Tietze, Abortion in the United States, 1978-1979, 13 Fam. Plan. Persp. 6-18 (1981).

3. I submit this declaration in support of plaintiffs' Motion for a Preliminary Injunction enjoining the implementation of proposed regulations promulgated by the United States Department of Health and Human Services (DHHS) under Title X of the Public Health Service Act (Title X). This declaration is based on data AGI has collected and analyzed, and based on my familiarity with the studies in this area. It is my expert opinion that the proposed regulations will irreparably harm women, particularly teenagers and poor women, who want to have an abortion. By prohibiting Title X-funded clinics from referring women to abortion providers, these regulations will create an insurmountable obstacle for many women: that of locating an affordable provider.

4. My opinion is based in part upon the results of a recent AGI national survey of all known abortion providers. This survey, covering the years 1984-1985 and fielded in 1986, is the ninth such survey conducted by AGI. The survey's findings are summarized in Henshaw, Forrest, and Van Vort, Abortion Services in the United States, 1984 and 1985, 19 Fam. Plan. Persp. 63 (Mar./Apr. 1987) (Exhibit B).

5. Although the annual number of abortions has stabilized since 1982, the number of abortion providers has declined significantly over the last few years. For example, in 1985 there were 5 percent fewer providers than in 1982. This decline in abortion availability has been concentrated in counties having only a few providers with small caseloads.

6. The geographic distribution of abortion providers is markedly uneven. Many women who live in rural areas reside in counties which have no facility that provides abortions. In 1985, 82 percent of U.S. counties had no identified abortion provider, and 30 percent of the women aged 15-44 live in these counties. Although women who live in counties that lack facilities can travel to another county, the need to travel can impose substantial hardships, especially on teenagers and low income women. Furthermore, the mere presence of a provider does not assure that a woman can obtain an abortion in her county of residence. Even in some counties which have providers availability of services may be limited if private physicians only serve their existing patients, or if providers are willing to provide abortions under limited or rare circumstances.

7. In New York State, there are 16 counties with no known abortion providers. An additional four counties each have one hospital which provides abortions only under extraordinary circumstances; these hospitals provide fewer than five abortions a year. More than one-quarter of a million women aged 15-44 live in the 20 counties with no or virtually no abortion services. On the basis of national abortion rates, one can estimate that between three and six thousand women in the 20 counties seek abortions each year and need information about where services can be obtained.

8. In many U.S. counties, a hospital is the only facility where an abortion can be obtained. Physicians in small communities may decide that the existing demand for the procedure does not warrant their equipping their offices to provide abortion services and such doctors may, therefore, prefer to use hospital facilities. In addition, hospitals are needed for instillation abortions and for high-risk patients. However, the 1986 survey showed that although hospitals constituted 44 percent of all known abortion providers, they were responsible for only 13 percent of the procedures performed in 1985. Furthermore the number of hospitals known to provide abortions has declined by 15 percent between 1982 and 1985. The reduction was somewhat larger among public facilities than among private ones (20% vs. 14%).

9. Large scale abortion providers (400 or more abortions per year) may be more prominent and thus more easily identified by patients. The presence of such facilities is a better indication of service availability by county than just the presence of providers of any size. The 1986 survey reveals that 92% of counties, where 43% of women live, have no such large-scale facility. Among non-metropolitan counties, 99% have no large-scale providers, and 91% have no abortion providers at all. Seventy-nine percent of all non-metropolitan women live in counties with no providers.

10. Although metropolitan counties are better served, coverage is far from complete: 65% have no providers that report at least 400 abortions per year, and half have none.

11. Though a provider may exist in an area, this does not assure that all women who need abortions will be able to obtain them. Abortion providers vary to some

degree in their policies and the specific services they offer, and 57% report that they do not perform abortions after the first trimester of pregnancy. Large clinics (a caseload of 2,500 or more) and those that operate for profit are more likely to perform second-trimester procedures than facilities with caseloads of less than 1,000. Hospitals are also more likely than private physicians to perform abortions at later gestations.

12. The new regulations impose a referral to prenatal or delivery services on every pregnant woman; referral is to be made by providing each woman with a list which is required to be weighted in favor of childbirth. This referral list cannot contain facilities which "principally" provide abortions. Seventy percent of all abortions in this country are performed at clinics which would likely be included within this definition or at clinics having no obstetrics services. Hospitals which provide abortions do so at costs which are prohibitive for most Title X patients. Many of the smaller metropolitan areas thus have no affordable abortion provider eligible for inclusion on the mandatory referral list.

13. Many women delay seeking abortions until their second trimester. There are several reasons for this. Some women only recognize that they are pregnant after several weeks or even months of gestation. Some have medical reasons which delay their decision. Other women who terminate their pregnancies do so after 12 weeks (10% in 1983).

14. Teenage women are even more likely to postpone an abortion until they are in the second trimester of pregnancy than are adult women. A recent report published by the U.S. Centers for Disease Control shows that adolescents, especially young adolescents, are

more likely to obtain abortions at later weeks of gestation when abortions increase in risk. Nationally, only 33% of abortions obtained by teenagers younger than 15 are performed at eight or fewer weeks of gestation, compared to 39% among 15-19 year olds and 54% of abortions to women aged 25-29. Fifteen percent of teenage women, nationwide, obtain abortions after 12 weeks, compared to nine percent of women age 20 and over. Tedd V. Ellerbrock et al., "Abortion Surveillance, 1982-1983," U.S. Centers for Disease Control, in CDC Surveillance Summaries, February 1987. MMWR 1987; 36 (No. 1ss).

15. By making it even more difficult to locate an affordable provider the Title X regulations will delay women seeking abortions to even later gestational ages.

16. Gestational age is an important determinant of abortion complications for all women. The mortality risk of abortion increases with advancing gestational age. At 13-15 weeks gestation, the risk of death from a second trimester procedure is 9 times as great as for a first-trimester abortion performed at 8 weeks or earlier, and abortions at 16 weeks carry a 24 times greater risk of death. Grimes, Second-Trimester Abortions in the United States, 16 Fam. Plan. Persp. 260-265, 263 (Nov./Dec. 1984). In addition, the tendency for teenagers to obtain abortions later in pregnancy has the largest single effect on the morbidity and mortality rates for abortion in this population. Cates, Adolescent Abortions in the United States, 1 J. of Adol. Health Care, 18-25, 20 (1980).

17. The proposed Title X regulations will affect a large number of women. According to the Department of Health and Human Services, Title X supports 3,900

family planning service sites. The most recent available data (1983) indicate that there are about 5,100 organized family planning clinic sites in the United States. These figures indicate that Title X, in whole or in part, funds 76 percent of these sites. The Alan Guttmacher Institute, Organized Family Planning Services in the United States, 1981-1983, New York, 1984. Data available from 1983 also indicate that 4,966,000 women were served in family planning programs that year. Id. Assuming that the caseloads of Title X clinics are similar to those of non-Title X clinics and that the number of women served in 1987 approximates the 1983 figures, about 3.8 million women (76 percent of the total) are served by Title X clinics.

18. In 1983, four-fifths of the contraceptive patients in organized family planning clinics had incomes below 150 percent of the official federal poverty level. Id. Under Title X, those under the official poverty level receive free services, and those with incomes between 100 and 250 percent of the poverty level pay on a sliding scale. Most of the women affected by the proposed regulations thus have low incomes and many of these women do not have the funds to pay for unsubsidized family planning services.

19. The most recent data (from 1983) also reveals that it can also be difficult to locate a family planning provider. During 1983, 2,462 different agencies were involved in the delivery of family planning clinic services. The provider agencies had organized family planning programs in 76 percent of the 3,135 counties in the United States. In that year there were an estimated 417,000 low income women under age 45 and 249,000 women under age 20 of all income levels at risk of unintended pregnancy who lived in the 757 counties that

had no organized family planning clinic services. Moreover, in eight percent of metropolitan counties where there were 117,000 low-income women and 79,000 teenagers in need, organized clinic programs were unavailable; while in 29 percent of the non-metropolitan counties with 300,000 low-income women and 171,000 teenagers at risk, there were no organized services.

20. Even without the proposed restrictions on Title X, there is a high incidence of unintended pregnancy particularly for teenagers. In 1982, for example, there were 3.3 million unintended pregnancies resulting in 1.3 million births, 1.6 million abortions and 0.4 million miscarriages. Teens, in particular, have an especially high risk of unintended pregnancy. In this same period, there were over 960,000 such pregnancies, resulting in 405,000 births, 430,000 abortions and 125,000 miscarriages.

21. It is my expert opinion that the proposed Title X regulations will irreparably harm women who seek reproductive health care at clinics receiving Title X funds. These women will be unable to obtain a referral to an abortion facility. For some of these women, particularly teenage women, locating an abortion provider on their own will subject them to increased risk of morbidity and mortality because pre-existing delays in seeking abortion services will be exacerbated by the necessity to search for a provider. Many of these women will be delayed into the second trimester of pregnancy while others may be deterred from terminating pregnancy altogether. Further, the regulations will have a disproportionately adverse effect on low-income women and teenagers who may be unable to locate or travel to an affordable, non-Title X-subsidized family planning provider where complete, non-directive

counseling, referral and information will be available. For these reasons, some of these women, at high risk of unintended pregnancy, will carry unwanted pregnancies to term.

WHEREFORE, I respectfully request that the court grant plaintiff's Motion for a Preliminary Injunction.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on:
February 5, 1988 /s/
Stanley K. Henshaw, Ph.D.

[Exhibits omitted.]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE STATE OF NEW YORK, ET AL.,	:	
Plaintiffs,	:	**AFFIDAVIT IN SUPPORT OF PRELIMINARY INJUNCTION**
- against -	:	
OTIS BOWEN, or his successor, Secretary of the Department of Health and Human Services,	:	**88 Civ. 0701 (Stanton, J.)**
Defendant.	:	

STATE OF NEW YORK)
)SS.:
COUNTY OF NEW YORK)

STEPHEN C. JOSEPH, M.D., being duly sworn, states:

1. I am the Commissioner of Health for the City of New York and a member of the Board of Directors of the New York City Health & Hospitals Corporation. I submit this affidavit in support of plaintiffs' motion for a temporary restraining order and/or preliminary injunction enjoining implementation of the regulations promulgated under Title X of the Public Health Service Act ("Title X").

2. The New York City Department of Health is vested with the responsibility of, among other things, ensuring the continued availability and accessibility of quality reproductive health care to all New York City residents.

3. The Title X regulations will impair, and possibly destroy, the ability of family planning clinics to render comprehensive, high quality medical care. The regulations will have a devastating impact on the reproductive health of thousands of low income women in New York City, as well as throughout the country.

4. The New York City Department of Health is not a direct Title X grantee, but it provides technical and consultative services to delegate agencies. It also provides education and information on reproductive health issues to the people of New York.

5. The Department sponsors the Pregnancy Healthline, a telephone service providing information and referrals on a wide range of reproductive health subjects. The Healthline staff counsel, refer, and make appointments for appropriate services. If unbiased information and counseling are no longer available through Title X clinics, due to these regulations, the Department's Healthline could become overloaded.

6. The regulations will harm the most vulnerable, high-risk people in the City: young low income women, including teenagers, substance abusers, and victims of Acquired Immune Deficiency Syndrome. Many of these women, for lack of appropriate information and counseling, will continue unwanted pregnancies, without seeking proper prenatal care. Children born under these circumstances are likely to have severe health problems

and even to die, contributing to the already unacceptably high infant mortality rate among the low income population of this City.

7. AIDS is the number one cause of death in New York City among women aged 25 to 34, the prime child bearing years when women most often use family planning clinics. Over 80 percent of the children who have been identified with AIDS in New York City were infected by their mothers. Three-quarters of the children with AIDS have died, most by the age of three.

8. Mothers of the overwhelming majority of children with AIDS in New York City are poor, minority women, members of a population which depends - usually solely - on Title X clinics for reproductive health care. Under the regulations, this population, which is at highest risk for AIDS transmission, would be the least equipped to cope with the possibility of exposure to the virus. Appropriate medical care requires providing a woman sufficient information about her conditions and alternatives so that she can reasonably decide her course of action. Every woman in New York City who is sexually active should consider her risk for HIV infection, and have access to responsible counseling about her risk of exposure and chances of transmitting AIDS to any children she conceives (almost 30 to 50 percent for an infected mother). For HIV infected women, the serious consideration of the option of abortion is vitally important. Yet such counseling would be impermissible under the regulations.

9. The regulations would seriously impair an established system of comprehensive family planning services in New York City at a time when it is faced with formidable challenges. Their implications for medical

providers, private and public health agencies and, ultimately, the reproductive health of low income women would be disastrous.

10. For the foregoing reasons, and based on my experience in the field of public health, it is my opinion that the Title X regulations will result in irreparable harm to many of the women who seek health care at Title X clinics.

WHEREFORE, I respectfully request that this Court grant plaintiffs' motion for a temporary restraining order and/or preliminary injunction.

Dated: New York, New York
February 5, 1988

/s/
STEPHEN C. JOSEPH, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE STATE OF NEW YORK, ET AL., DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	**AFFIDAVIT**
- against -	:	88 Civ. 0701/02
OTIS BOWEN, or his successor, Secretary of the Department of Health and Human Services,	:	(LLS)
Defendant.	:	

STATE OF NEW YORK)
)SS.:
COUNTY OF NEW YORK)

STEPHEN C. JOSEPH, M.D., being duly sworn, states:

1. I am the Commissioner of Health for the City of New York and a member of the Board of Directors of the New York City Health & Hospitals Corporation. I submit this affidavit in opposition to defendant's motion for summary judgment.

2. The occurrence of infant mortality and low birth weight are extremely high among low income women, who constitute the population served by Title X

clinics. For example, in the areas of New York City with lowest median family income, the infant mortality rate in 1986 was nearly double the rate in areas with highest median family income.

3. The major reason for both low birth weight and infant mortality is the lack of proper prenatal care. Failure to receive prenatal care is detrimental to the health of both mother and baby. Financial barriers and ignorance are the major reasons that low income women, fail to receive proper prenatal care. Because Title X clinics are an important source of information about pregnancy and prenatal care for the low income population, the new regulations will only exacerbate the infant mortality and low birth weight statistics in this population.

4. These two related problems are also extremely common among teenagers, who generally constitute 20-30% of the clients of Title X clinics. In 1986, teenagers in New York City gave birth to low birth weight babies at a rate of 11.7%, compared to the overall New York City rate of 9%, the mortality rate of babies born to teenagers in New York City in 1986 was 16.9 per 1000 live births, as opposed to 12.8 per 1000 in the overall population. These figures stem in part from the fact that teenagers are much less likely to get prenatal care than adult women. Of the women who gave birth in New York City in 1986, 32.9% of the teenagers had little or no prenatal care, whereas 19.3% of the non-teenage women giving birth lacked prenatal care.

5. Title X clinics are sources of both health care services and information. In fact, they are the sole source of non-emergency health care for many low income women. Even clinics which have no extensive

program of provision of prenatal care still provide patients with a great deal of information about prenatal care and pregnancy.

6. If the new regulations are enforced, the Title X clinic will be compelled either to abide by rules which conflict with its medical and ethical standards, or lose a substantial portion of its budget. Either alternative will result in a decline in prenatal care among the women who need it most.

7. If the clinic chooses not to continue federal funding, it will be forced by simple economics to accept and treat fewer patients. This decline in the number of patients a clinic sees can only lead to more unwanted pregnancies and fewer patients who receive prenatal information, referral and care -- which, in turn, will lead to increased instances of low birth weight and infant mortality.

8. If the clinic chooses to continue receiving federal moneys, its credibility with its patients, and therefore its usefulness, will decline. When patients learn the clinic can no longer give them honest, direct and complete answers to their questions about abortion, they will become reluctant to trust clinic personnel for any purpose, including prenatal care advice.

9. Under the new regulations, the Title X clinic can no longer explain to a patient that her medical condition (for example, AIDS) or some other factor (for example, exposure to rubella) may have seriously damaged her fetus. The clinic can only refer her to another provider, on the assumption and in the hope that the next provider will counsel her appropriately. In the meantime, the patient will remain ignorant of the

information she needs -- as soon as possible -- to determine whether she wants to risk delivering a severely damaged baby. By the time she gets this information, it may be too late for a first trimester, or for any, abortion.

10. An additional factor in the infant mortality area is the new requirement that Title X clinics completely separate their family planning activities from Title V activities. Title V provides funding for genetic testing and counseling. This program lowers the probability that babies will be born with genetic defects, and thereby also lowers the infant mortality rate. Title V programs include counseling about the possibility of aborting damaged fetuses, and such discussion cannot be conducted on the same premises with Title X activities. Most clinics will be financially unable to implement this kind of separation, and will therefore discontinue their participation in Title V programs, which are one of the only sources for genetic testing and counseling for the low income population. Thus this program, the purpose of which is to increase the likelihood that low income women will bear healthy babies, will be discontinued in many Title X clinics.

11. For the foregoing reasons, and based on my experience in the field of public health, it is my opinion that the Title X regulations will increase the incidence of low birth weight infants mortality among the low income population of New York City.

Dated: New York, New York
March 4, 1988

/s/
STEPHEN C. JOSEPH, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	DECLARATION OF JAY KATZ, M.D.
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	Civ. No. 88-0702 (LLS)
Defendant.	:	

I, JAY KATZ, M.D., declare and state as follows:

1. I am a Board Certified Psychiatrist and have been on the faculty of Yale Law School for thirty years. I have published over forty articles and five books, including three books concerning informed consent, titled Experimentation With Human Beings, Catastrophic Diseases-Who Decides What?, and The Silent World of Doctor and Patient, and two other books titled The Family and the Law and Psychoanalysis, Psychiatry and the Law. Titles of articles I have written include the following: "Informed Consent: Are 'Miracle, Mystery and Authority' Better Medicine?"; "Can Principles Survive In Situations of Critical Care?"; "The Senate's Definition of Voluntary and Informed Consent: Another View"; "Disclosure and Consent - In Search of Their Roots"; and, "Informed Consent in the Therapeutic Relationship:

Medical and Legal Aspects." I am a Diplomate of the American Board of Psychiatry and Neurology and a Member or Fellow of numerous learned societies including the Institute of Medicine of the National Academy of Sciences, the American Psychiatric Association, American College of Psychiatry, and the American Psychoanalytic Association, where I am Chairman of the Committee on Psychoanalysis and Legal Issues and Legal Review. My Curriculum Vitae and Bibliography are attached hereto as Exhibit A.

2. Furthermore, I have testified as an expert witness on the effects on patient health of government interference in the doctor-patient relationship in Akron v. Akron Center for Reproductive Health, 479 F. Supp. 1172 (N.D. Ohio 1979), aff'd in part rev'd in part, 651 F.2d 1198 (6th Cir. 1981), aff'd in part rev'd in part, 462 U.S. 416 (1983) and in a case in Louisiana. In both cases, I was recognized as an expert witness on the question of bioethics, informed consent, and health effects of interfering in the doctor-patient relationship.

3. I have studied the new regulations promulgated by the United States Department of Health and Human Services ("HHS") under Title X of the Public Health Service Act ("Title X"). 53 Fed. Reg. 2922 et seq. (February 2, 1988).

4. I am making this declaration in support of plaintiffs' Motion for Summary Judgment and in opposition to defendants' Motion for Summary Judgment.

5. I am unequivocally opposed to the implementation of these regulations which radically depart from basic principles of informed consent, and

threaten to impair substantially the doctor-patient relationship.

6. By requiring a physician to steer a pregnant woman toward childbirth, to refuse to disclose information about alternatives and to terminate his relationship with a patient in need without counseling or assistance, these regulations do violence to the most basic principles governing the doctor-patient relationship. They compel a doctor to deceive his patient by keeping available options from her and by preventing her from seeking medical services which heretofore have been her right. It is this deception which I wish to highlight to the Court. When a physician conceals options from a patient he abandons her to irreversible life consequences which she might not have chosen. Abandonment is one of the most heinous violations of the law of malpractice and of medical ethics.

7. The doctor-patient relationship is based on trust. See P. Parsons, The Social System, (1951); it is recognized by law as a fiduciary relationship. Because patients must be able to rely on their physicians to act in good faith and in their best interest, principles of law and ethics require them to do so.

8. The physician thus has an obligation to be truthful, to respect the rights of the patient, and to disclose to the patient all pertinent facts regarding the patient's condition and treatment options including the risks and benefits of each. See Natanson v. Kline, 350 P.2d 1093, 1102-03 (Kan. 1960).

9. The Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) (1986) specifically acknowledge that:

> The patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for [her] care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

Opinion 8.07. Further, the standards of the American College of Obstetricians and Gynecologists state that "the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy."

10. While patients should not necessarily be able to insist upon any treatment they choose or that any physician provide it, their wishes ought to be heard and explored, not stifled by requirements on a physician to censor the full range of alternatives available to them. Thus, although a Title X physician may not actually provide abortion or long-term prenatal services, the physician remains obligated to provide the patient with sufficient information to permit a patient to obtain timely, appropriate services elsewhere.

11. In 1978, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (the "Commission") was

established by statute and charged with the task of examining the ethical and legal aspects of informed consent in the doctor-patient relationship. See 42 U.S.C. § 300v et seq. The Commission's report, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, (excerpt attached as Exhibit B), was released in 1982. It relies, in part, on my publications. The Commission concluded that "a physician is obliged to mention all alternative treatments, including those he or she does not provide or favor, so long as they are supported by respectable medical opinion." See Exhibit B at 76 (emphasis added).

12. Abortion was a recognized medical procedure long before 1970. In fact, when Title X was enacted, abortion was widely available under differing circumstances in different states. Thus, a physician at this time had an ethical duty to disclose the availability of the abortion option regardless of its legality in his home state.

13. Although in some respects legal standards have lagged behind those established by the medical profession, this has not uniformly been the case. In the past quarter of a century, American courts, supported by legal and ethical commentary, have articulated a requirement of "informed consent" which requires health care practitioners to disclose and discuss information pertinent to treatment choice with their patients. The first such case was decided in 1957, Salgo v. Leland Stanford, Jr., University Board of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957). See Canterbury v. Spence, 464 F.2d 772, 780 n. 13, 781 nn. 19 & 22, 782 nn. 28, 30 & 31 (D.C. Cir. 1972) (and cases cited therein); Natanson v. Kline, 350 P.2d 1093 (Kan. 1960).

14. The doctrine of informed consent or physician-disclosure was full blown by 1970 when Congress enacted Title X. Indeed, one of the most well known cases on the subject was decided in the District of Columbia in 1972, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir[.] 1972). Noting the "root premise" of American jurisprudence that "[e]very human being ... has a right to determine what shall be done with his own body," 464 F.2d at 780 (quoting Cardozo in Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92, 93 (1914)), the Court stated:

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.

464 F.2d at 780 (footnotes omitted) (emphasis added). This duty may further oblige the physician to advise the patient to consider one alternative over another depending on the medical circumstances. Id. at 781.

15. The scope of this duty should be measured by the patient's need for information and can not ethically be governed by a requirement of law inconsistent with the best interest of the patient.

16. This doctrine of informed consent has been codified in New York under the Public Health Law which provides:

> Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient each alternative thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

N.Y. Public Health Law § 2805-d(1) (McKinney) (emphasis added). Physicians "have a duty to provide a reasonable explanation of the avoidable alternatives and potential dangers of a medical procedure." Nisenholtz v. Mount Sinai Hospital, 126 Misc. 2d 658, ___, 483 N.Y.S.2d 570 (Sup. Ct. 1984).

17. These cases recognize what HHS now seeks to destroy: "the prerogative of the patient, not the physician [or, indeed, the federal government], to determine for [her]self the direction in which [her] interests seem to lie." See Canterbury v. Spence, 464 F.2d at 781.

18. At least since Roe v. Wade was decided in 1973, a woman's right to abortion has been constitutionally protected. Under these regulations, a physician is confronted with an impossible dilemma: he must either honor his ethical obligation to respect the rights of his patient as established by the United States Supreme Court and embraced by the AMA, or comply with the new Title X regulations in order to retain

funding which enables him to treat low-income women. Because a physician is ethically bound to choose the first of these options, the Title X program will be crippled by attrition as all self-respecting physicians opt out of the program. Low-income women will be worse off than if Title X had never been enacted.

19. The third Principle of Medical Ethics states: "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient." For this reason, I submit this declaration in support of the relief sought by plaintiffs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed this ____ day of March, 1988.

/s/
JAY KATZ, M.D.

[Exhibit A omitted.]

Exhibit B to Declaration of Jay Katz: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (1982)

* * * *

Treatment Alternatives and the Professional's Recommendation. In order for medical intervention to be warranted, the patient must stand to gain more from some intervention than if none were undertaken at all. As noted previously, the benefit to be gained must be assessed in terms of the patient's own values and goals. Thus, a practitioner should be cautious not to rule out prematurely an alternative that might offer what a particular patient would perceive as a benefit even if the practitioner sees it differently.

The patient's condition and the range of available alternatives will necessarily shape the course of the discussion. In some instances, there may be only one medically recognized treatment, so that the decision is primarily between that treatment and no treatment at all. In such cases, discussion will naturally focus on the benefits and risks associated with that treatment compared with the likely course of the untreated disease. Time is an important dimension here: can an intervention be put off, and with what consequences, to allow for greater diagnostic certainty and to permit the patient to reflect on the decision and to engage in any desired activities with which the intervention might interfere?

More commonly, there will be a range of medically acceptable responses to a given disease or health condition. The decision then has two components: <u>whether</u>

to treat and how to treat. Here the discussion will typically require a comparison of several treatment options and an airing of the preferences of both professional and patient.

Since the judgment about which choice will best serve well-being properly belongs to the patient, a physician is obliged to mention all alternative treatments, including those he or she does not provide or favor, so long as they are supported by respectable medical opinion. For example, an internist has an obligation to discuss a surgical option with a patient who might benefit from it. In any case[,] the physician would ideally offer to refer the patient to a physician who does offer or favor the alternative treatment.

Similarly, a physician ought not withhold information about a treatment from a patient simply because the physician judges its potential benefits not to be worth its costs.[15] Increasingly, however, even when physicians fulfill their obligation to describe alternatives, the expense of some alternatives may make them unavailable to most patients. Ordinarily, alternatives should still be described, even though they would not be covered by a patient's insurance plan (if any) or enrollment agreement with a health maintenance organization, lest the patient be deprived of the opportunity to seek other avenues for paying for the treatment or to look for treatment outside the insured or prepaid options.

Plainly, the special rules and expectations generated for the patient-professional relationship by the legal and ethical precepts summarized in the requirement of in-

[15] Nothing in the obligations that arise within the patient-professional relationship precludes physicians, individually or collectively, from taking steps to make the health care system more efficient, including the elimination of treatment options that do not produce a favorable cost-benefit ratio in particular cases.

formed consent find no precise equivalent in commercial relationships in the insurance marketplace. Nonetheless, because of the close connection between health insurance (including prepaid group plans) and health care, both the sellers and the buyers of such insurance should make sure buyers receive a comprehensible explanation of the limitations in what they are purchasing. Otherwise, their subsequent decisions at the time of selecting among treatment alternatives may not in any real sense be either voluntary or informed.

The Commission does not believe that each alternative must be discussed in comprehensive detail. Rather, the professional should initially set forth, in a fairly general way, the nature and implications of the various options. Such a discussion can and should be used to "sound out" what is important to the patient and to identify the options likely to prove most satisfactory in light of the patient's values and preferences. Once the options (including the possibility of no treatment) have been pared down to those that seem most promising to patient and professional, a more detailed evaluation of the risks and benefits is appropriate. Attention should be devoted as well to the time dimension and finality of the choice, and to the possibility of a sequential approach to various alternatives. In this process, the Commission views the discussion of risks and benefits as a step toward a sound decision among alternatives, not a supreme objective in itself.

This Report, like many discussions of informed consent, places considerable stress on the patient's right of self-determination, including the right to choose among available treatments or to reject a particular treatment. Yet the Commission does not mean to suggest that professionals must take a neutral position among available alternatives. Physicians ordinarily do make recommendations to patients, and many patients would be quite dis-

concerted if they were rebuffed when they requested a "doctor's opinion." Indeed, a critical aspect of the professional's role is to provide expert advice and judgment, and not solely technical diagnostic or curative skills. But the recommendation should neither be, nor appear to be, coercive; rather, it should function both as a yardstick against which patients can measure their own inclinations and as a stimulus to further questioning and discussion if the recommendation is not one the patient agrees with.[16]

* * * *

[16] In making treatment recommendations the health care professional may indicate what his or her own values are. To the extent that a particular recommendation is based on the professional's values, rather than the patient's values, that should be made clear. For example, a physician may recommend that an athlete retire from competition because it is harming his or her health. The athlete, however, may want to remain in professional competition as long as possible. The physician may reply that the patient's view is shortsighted and that health is more important than another year of professional sports. Once having stated the recommendation, however, and having made clear the values that led the physician to the recommendation, the choice remains the patient's. When there are a number of medically appropriate treatment alternatives, the decision among them may also turn on value preferences. For example, a physician who feels strongly that kidney transplant is preferable to renal dialysis is likely to be stating a value preference rather than a purely medical conclusion. In such situations, physicians should recommend that the patient consult with another expert with opposite views before making a final decision. In both examples, clarification of the professional's values is likely to provoke a useful discussion of the patient's values. *See, e.g.*, Robert M. Veatch. *Generalization of Expertise*. 1 THE HASTINGS CENTER STUDIES 29 (1973).

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	**DECLARATION**
		88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

TONI MORGAN, being duly sworn, deposes and says:

1. I am Director of Social Services for the Bronx clinic (colloquially called the "HUB") of Planned Parenthood of New York City. I have been at the HUB since February, 1987. Previously, from 1981 to 1986, I was employed as a social worker in the adolescent health center of Mt. Sinai Medical Center where I counseled teens regarding sexuality, pregnancy, abortion and other matters which frequently concern them. In 1983, I began training social work students to counsel adolescents in these areas. I was certified as a social worker by the state of New York in 1980. See Resume attached hereto as Exhibit A.

2. I submit this affidavit in support of plaintiffs'

Motion for a Preliminary Injunction enjoining implementation of the proposed regulations promulgated by the United States Department of Health and Human Services (HHS) under Title X of the Public Health Service Act ("Title X"). I make this affidavit in my capacity as an expert in teen counseling employed by a subgrantee of Title X funds.

3. I have studied the new regulations. Based upon my experience with the HUB's family planning activities and my professional training, it is my opinion that the proposed regulations will cause irreparable harm to the HUB and to those individuals who seek counseling at the HUB, particularly sexually active adolescents.

4. Consistent with Title X and current HHS regulations and program guidelines, the HUB provides counseling and referral for family planning patients about contraception, prenatal care, abortion and other related issues. Ideally, social workers at the HUB would counsel every adolescent patient who requests a pregnancy test, regardless of the test result. This is because sexual activity can be an indication of rebellion, unmet needs, or of trouble as much as of normal maturation. However, due to patient volume, HUB social workers limit their counseling to early adolescents, patients requiring crisis intervention, and to those family planning patients referred to them by health care staff. In other instances, patients are counseled by "client assistants."

5. Many of the pregnant adolescent patients receiving counseling services at the HUB have not yet decided whether to abort or continue their pregnancy. No responsible family planning clinic can operate without counseling such adolescents as to all of their

available options, including that of abortion. See Counseling: A Manual for the Staff of Planned Parenthood of New York City, Inc. at 11, 23-4 (1983). Moreover, an adolescent's unwanted pregnancy can raise many unresolved issues. Thus, even after an abortion or a full-term pregnancy it is imperative that patients be referred back to a counseling program, preferably to the same counselor. Follow up of this sort is an important part of an effective medical program in the area of reproductive health as well.

6. Adolescents frequently rely on clinic staff as the only available source of family planning information. They need comprehensive counseling in a value-free context in order to arrive at an informed choice which is right for them.

7. For teens, reproductive choices such as whether and with whom to become sexually active, whether to use contraception, which method to use, and what to do in the event of an unintended pregnancy are all made in the social, psychological and developmental context of adolescence. These choices are highly inter-related. Thus, a minor's concerns or desires regarding pregnancy or childbirth may affect her choice whether to become sexually active and whether to contracept. Her feelings about her sexual partner and whether she had been using birth control may affect her feelings about pregnancy and the options of childbirth and abortion. Life [am]bitions, parental and family relationships, personal history and the availability of financial and emotional resources must all be considered.

8. Timely, non-directive counseling which addresses the whole adolescent is a necessary part of any family planning program. In fact, when an adolescent is

in need of counseling and this need is not met promptly, the consequences may be as serious as repeated pregnancies, running away from home, failure in school or even suicide. Referral alone will often result in severe harm to the adolescent who, having timidly and tentatively reached out for help in a crisis, must be rejected and told to go elsewhere. Faced with such a referral, many of my clients would never obtain help; others would act out in destructive and frequently irrevocable ways.

9. All individuals must have continuity in their relationship with social workers or counselors in order to establish the trust and confidence that is a necessary prerequisite to effective counseling. The proposed regulations require that once a client is diagnosed as pregnant she must terminate even an ongoing counseling relationship with a Title-X funded social worker at a Title X program. An adolescent, in partic[u]lar, will feel betrayed and uncared for and her relationship with her counselor will suffer irreparable damage. She may react by refusing help offered by other adults. It may permanently harm her ability to accept and trust <u>any</u> subsequent counseling relationship.

10. For example, one seventeen-year old girl was referred to a HUB social worker regarding her feelings of depression. Over the course of a continuous counseling relationship, she revealed her early childhood experiences of sexual molestation by her older stepbrothers; her conflicted relationship with an older man, and her concern that she might be pregnant. When her suspected pregnancy was subsequently confirmed, the adolescent's trust in the therapeutic relationship enabled the counselor to involve members of the girl's family, who were previously unaware of both the molestation

and the pregnancy, in the resolution of these problems. Such comprehensive counseling increased the adolescent's previously low self-esteem and gave her the necessary confidence to deal with the pregnancy in a way best suited to her needs and to improve her intimate relationships with her family and with others.

11. Another girl, fifteen years old and with a history of sexually transmitted disease (STD) was referred to a HUB social worker for counseling. As her confidence in the counseling relationship progressed, the adolescent was able to reveal her experiences of abuse and neglect by her mother. She was also able to discuss her pregnancy and the resulting fear which had led her to run away from home in an attempt to avoid her mother's physical reprisals. Working with her counselor, the adolescent was able to resolve her pregnancy crisis and to make family planning decisions to prevent future sexually-related medical difficulties and to avoid future pregnancies. Moreover, her HUB social worker discovered the mother's drug dependency and was able to substantiate the mother's abusive behavior. Pursuant to a neglect proceeding, the mother's ability to care effectively for her adolescent daughter with the assistance of supportive treatment is currently under evaluation.

12. In both of these cases, termination of the counseling relationship at the point of pregnancy diagnosis would have prevented any resolution of the issues raised in treatment. It would also have endangered the physical and emotional health of the patient involved. The abrupt disruption of a trusted counseling relationship is <u>never</u> inconsequential.

13. It is my professional opinion, that the new Title

X regulations will result in irreparable harm to the physical and mental health of the indigent women and adolescents who are my patients and to the provision of responsible family planning services in Title X-funded facilities, such as the HUB.

WHEREFORE, I respectfully request that the Court grant plaintiff's Motion for a Preliminary Injunction.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on:
12/22/87 /s/
Antonia Cordero Morgan, M.S.W.

[Exhibit omitted.]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	**DECLARATION**
		88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

GEORGE W. MORLEY, M.D. deposes and says the following:

1. I am President of the American College of Obstetricians and Gynecologists ("ACOG"). I have been an active member of ACOG for 30 years and have held leadership positions in the organization at the state, district and national levels. I have served as the President of ACOG since April of 1987.

2. I am a licensed physician with residency training in obstetrics and gynecology. For the past 31 years, I have worked in the field of academic medicine at the University of Michigan Medical Center, and was recently appointed the first Norman F. Miller Professor of Gynecology at that institution. From 1974 to 1986 I held the position of Director of the Gynecologic Onco-

logy Division of the Obstetrics and Gynecology Department at the University of Michigan Medical Center. I have served as a consultant in obstetrics and gynecology at Westland Medical Center from 1961 to 1986 and at the United States Veterans Administration Hospital in Ann Arbor, Michigan from 1957 to the present.

3. Over the course of my career, I have served as President of the Michigan Society of Obstetricians and Gynecologists, the Society of Pelvic Surgeons, the Society of Gynecologic Oncologists, and the Society of Gynecologic Surgeons. I have published more than 50 articles in the areas of obstetrics[,] gynecology, and oncology. A copy of my resume is attached as Exhibit A.

4. I submit this declaration in support of plaintiffs' Motion for a Preliminary Injunction enjoining implementation ofnew regulations promulgated by the United States Department of Health and Human Services ("DHHS") under Title X of the Public Health Service Act ("Title X"). I submit this declaration in my capacity as the President of ACOG, a national medical organization of more than 27,000 physicians specializing in the delivery of health care to women.

5. I have studied the new regulations. In my professional opinion and in the opinion of ACOG, I believe that the regulations will cause irreparable harm to women, particularly to poor women and adolescents, as well as to the integrity of the services provided by physicians at Title X-funded clinics.

6. Every year, some 3,900 Title X clinics provide family planning services to nearly 4.5 million patients, many of whom are low income women or adolescents with high risk pregnancies and few of the financial or

personal resources necessary to obtain private medical care. By prohibiting these clinics from offering counseling and referral for abortion as well as from providing any services to women diagnosed as pregnant, the regulations will (1) cause many pregnant patients to delay obtaining prenatal care or abortion-related services; (2) subject many of these women to unwanted motherhood by default or to unnecessarily high risk pregnancies and births due to the absence of prenatal care; (3) inhibit health care professionals from exercising their professional judgment by subjecting them to the risk of ethical disciplinary procedures or malpractice liability; and (4) reduce the availability of family planning and reproductive health services nationwide.

7. ACOG is concerned that the regulations present family planning providers with an untenable dilemma: they must either accept Title X funds and comply with conditions which conflict with sound medical practice or refuse these funds and be unable to afford to continue providing reproductive health services to those who cannot pay or, indeed, provide these services at all.

8. In those clinics which retain Title X funds, the regulations perpetuate a dual standard of medical care: one for patients served in federally-funded Title X clinics and another for patients who can afford private care. Patients at Title X clinics will receive only government-sanctioned family planning information, and may have no knowledge that complete and unbiased information is available to those women with the ability to pay. Because poor women and adolescents will be forced to accept the incomplete and potentially inaccurate information available from Title X providers, they will be unable to make truly informed family planning decisions.

9. As a professional association committed to maintaining high standards of health care for all women, ACOG opposes conditions on federal grants to providers which require them to undermine these standards. ACOG believes that federal subsidies for reproductive health care should manifest respect for professional judgment, increase the availability of high quality care and attempt to equalize access to such care for those without alternative resources. Contrary to such aims, these regulations will undo the achievements of the Title X program and will harm women in the following ways.

10. If a patient decides to carry her pregnancy to term, compliance with the regulations will endanger her own health and that of her infant. For many poor women and adolescents, the Title X health care provider will be the only professional consulted during the early months of pregnancy. By limiting counseling once pregnancy is diagnosed, the new regulations will exacerbate existing delays in obtaining prenatal care which is common among the patient population served by Title X clinics. According to a recent Government Accounting Office report, 63% of Medicaid recipients and uninsured women fail to obtain sufficient prenatal care. In addition, data from the National Center for Health Statistics shows that less than half of pregnant 15 to 17 year-olds receive care in the first trimester of pregnancy.

11. This failure to obtain early and adequate prenatal care stems from a variety of factors such as cost, unavailability, lack of resources or information, or a failure to understand the importance of such care. The proposed regulations will make these obstacles to proper prenatal care worse. Failure to obtain early and adequate prenatal care is a major factor contributing to

the high infant mortality rates among low income women and adolescents who carry to term.

12. The prohibition on counseling and referral for abortion may similarly delay women in obtaining abortion services until later and more hazardous stages of pregnancy. Abortions performed later in pregnancy carry increased morbidity and mortality risks. Although only a small percentage of abortions are performed during the second trimester of pregnancy, these abortions caused approximately half of all abortion-related deaths between 1972 and 1981. Moreover, the mortality risk for abortion increases 50 percent with each week after the eighth week of pregnancy while the risk of major complications (morbidity) increases about 30 percent per week. Delay in obtaining abortion services is thus particularly harmful for pregnant adolescents, who already tend to seek medical services belatedly.

13. The requirement that pregnant patients be referred only to prenatal or delivery services will further delay women seeking abortions. Some of these women may be unable to locate a licensed provider in a timely fashion. In addition, the requirement that every pregnant patient be given information on prenatal care creates a federally subsidized affirmative pressure to carry to term. By mandating delay in abortion services and by limiting counseling, referral and information, and by steering women toward the option of childbirth, the new regulations will lead some women to carry to term against their will thereby increasing the incidence of unwanted motherhood.

14. The prohibition on counseling regarding abortion undermines the very informed consent process for which physicians are responsible. Patients will be

deprived of information necessary to make family planning and other health care choices.

15. Pregnant patients will have to decide whether to carry a pregnancy to term without crucial information about the abortion option and the existence of licensed abortion providers. Inappropriate and misleading referrals to prenatal or delivery services together with a lack of counseling and information will act to steer pregnant women toward only one of their available options, thus further undermining informed, voluntary reproductive choice.

16. The regulations will expose adolescent patients at Title X clinics to additional harms specific to teenagers. Although ACOG urges adolescents to postpone sexual activity, every year 2.4 million women in the United States under the age of 18 are at risk for pregnancy because they are in fact sexually active. Pregnant adolescents run considerably higher risks of maternal mortality, maternal morbidity and low infant birth weight. Comprehensive and effective family planning and prenatal services can greatly reduce such risks. By seriously disrupting the continuity of Title X-funded health care for such an at-risk population, the regulations threaten the lives and health of innumerable adolescents and their infants. Teenage pregnancy and childbirth are associated not only with medical difficulties, but also with severe social and economic problems. For example, in 1986 the United States spent 18 billion dollars in public assistance payments to households in which the mother was a teenager when her first child was born.

17. Further, the regulations will endanger the lives and health of those women with medical conditions

which may be exacerbated through continued pregnancy. Health care providers will not be able to discuss medical indications for abortion with a pregnant patient diagnosed for any number of conditions such as cardiac and renal conditions and Acquired Immunodeficiency Syndrome ("AIDS"), despite the fact that pregnancy may increase the risks both of progression of the infection and of development of AIDS or AIDS-related complex. Similarly, a woman who has an estrogen-dependent tumor which will spread more rapidly due to hormonal changes associated with pregnancy will not receive the counseling and referral for abortion which are essential to her health. Only a referral to prenatal or medical services is permitted.

18. The regulations also will irreparably harm Title X-funded health professionals by causing them to violate the standards of conduct and ethics promulgated by ACOG and other professional organizations. Restrictions on the content of physician-patient counseling are contrary to the ethical practice of medicine and violate a basic medical principle: the duty of the health care provider to supply all pertinent information to the patient.

19. The Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association-1986 (Exhibit B) [see pp. 79-81 of this joint appendix] dictate that: "[t]he patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." ACOG has elaborated on this principle of informed consent in the area of pregnancy. Specifically, ACOG Standards for Obstetric-Gynecologic Services (1985) (Exhibit C) [see pp. 77-78 of this joint appendix] state:

> In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy

and ACOG Statement of Policy (Dec. 1977) (Exhibit D) [see p. 76 of this joint appendix] states:

> Counseling directed solely toward either promoting or preventing abortion does not sufficiently reflect the full nature of the problem or the range of options to which the patient is entitled. Appropriately balanced counseling, combined with the available and accessible facilities, provides the minimum base for the opportunity to make a truly informed choice. (Emphasis added)

20. The practice of good medical care demands open communication between health care professionals and their patients. If physicians are prevented from engaging in uninhibited, active interchange with the patients they serve consistent with professional judgment under the circumstances, patients cannot receive optimum care.

21. Restrictions on a physician's ability to provide information to patients also raises the spectre of medical malpractice. Physicians may be liable for failure to fully inform patients of all alternative options, failure to provide adequate information regarding health risks, and failure to provide appropriate follow-up services. A physician has the professional responsibility to counsel a pregnant patient with a genetic disease such as Tay-Sachs

that abortion exists as a medical option. By prohibiting health care providers from following standard medical protocol in such situations, the regulations will expose health care providers to the irreparable harm of legal liability and professional discipline.

22. The chilling effect of threatened professional censure, loss of license or legal liability for malpractice will deter providers from participating in Title X family planning programs. The resulting restriction in the availability of quality services will cause irreparable harm to patients who cannot afford private medical care.

23. Finally, ACOG is concerned that the regulations will impose heavy financial burdens on Title X health care providers and will decrease the quality of patient care. Many hospitals and ciinics maintain a single, integrated set of records. Because optimal patient care requires that health care providers have access to all information about a patient, it is imperative that this system remain undisturbed.

24. For the foregoing reasons, and based upon my experience in the field of Obstetrics and Gynecology, it is my opinion that the proposed Title X regulations will result in irreparable harm to patients, particularly to the indigent women and teens Title X was designed to serve, and will undermine the integrity and the quality of Title X-funded services.

WHEREFORE, I respectfully request that the Court grant plaintiff's Motion for a Preliminary Injunction.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 2/1/88

/s/
George W. Morley, M.D.

[Exhibit A omitted.]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

PEOPLE OF THE STATE OF NEW YORK, ET AL.,	
Plaintiffs,	AFFIDAVIT OF KATHLEEN MURRAY IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION
- against -	
OTIS BOWEN, Secretary of the United States Department of Health and Human Services,	
Defendants.	

STATE OF NEW YORK)
: SS.:
COUNTY OF ERIE)

KATHLEEN MURRAY, being duly sworn, deposes and says:

1. I am the Assistant Vice President for Ambulatory Care of the Buffalo General Hospital (the "Hospital"), a comprehensive health care system in Buffalo, New York which includes the Deaconess Hospital of Buffalo ("Deaconess") and which is a primary affiliate of the Faculty of Health Sciences of the State University of New York at Buffalo. As Assistant Vice President for Ambulatory Care, I oversee the Deaconess Family Planning Program ("DFPP"). I submit this

affidavit in support of plaintiffs' motion for a preliminary injunction to enjoin the implementation of the newly promulgated Title X regulations.

A. The Deaconess Family Planning Program

1. Organization, Funding and Clientele

2. DFPP operates three family planning clinics, none of which are located at the Hospital itself. Our Riley Street Clinic is located approximately ten blocks away from the Hospital; the High Street Clinic is located behind the Hospital and the Akron Clinic is located in Akron, New York, a small rural community approximately twenty-five miles outside of Buffalo.

3. The Riley Street Clinic operates on a full time basis, serving approximately 140 persons each week. The High Street and Akron Clinics each operate on a part time basis and each serve approximately 25 to 30 individuals weekly.

4. DFPP's anticipated income for Fiscal Year 1987-88 is approximately $700,000. Our Title X funding will total $237,836, or 34% of our total budget. Other sources of funding include medicaid reimbursement, the New York State Department of Health, private funds and patient fees. DFPP's budget is separate from that of other Hospital clinics and departments.

5. At the present time, DFPP employ[s] the equivalent of almost eighteen full time workers, including physicians, counselors, nurse practitioners, and educators. DFPP staff do not rotate through the Hospital's other staff, but are paid through the Hospital's payroll Department.

6. The majority of DFPP patients are poor black women, almost half of whom are under the age of 20. In 1986, DFPP served 4,283 unduplicated users, of whom approximately 87% had incomes below 150% of the poverty level. Approximately 49% of these women are between the ages of 10 and 19, and the vast majority of them are between the ages of 18 and 22. Of the patients served between January 1 and September 30 of this year, almost 79% had incomes less than 100% of the poverty level. DFPP is often the first and only entry to nonemergency health care for this population. It is the major provider of reproductive health care for the black community in Buffalo.

7. An increasing number of our patients are among the working poor who are ineligible for medicaid and yet without other adequate health insurance. These women depend on our sliding fee scale made possible by Title X.

2. Services Provided by DFPP

8. DFPP provides a range of family planning and health screening services, including discussion and provision of all methods of birth control, both prescription and non- prescription; gynecological examinations; diagnosis and treatment of venereal diseases; pregnancy testing with counseling and referrals; breast examinations and screening for anemia and sickle cell anemia. DFPP does not perform abortions.

9. DFPP conducts a wide variety of educational programs in our service area including programs on reproductive health care and birth control. And because so many of our patients are low income teenagers, DFPP runs a number of special programs aimed at teens, such

as programs on self-esteem and on saying "no". Our education programs are funded in part by Title X and are presented through community organizations and service agencies, churches and local clubs.

10. Our special education and teen programs have been extremely successful when judged by DFPP's growth rate of 10% to 27% per year over the last six years. Our retention has improved from 65% in 1981 to 89% in 1986. This growth means a reduction in unplanned, unwanted pregnancies in the area we serve.

11. DFPP's professional staff attempts to develop personal relationships with all of our patients and to see them on a regular basis. Indeed, the great majority of our patients are seen every six months for a check up. If a patient fails to make an appointment for a six month check-up, we send her a series of reminder letters. Moreover, DFPP maintains a close relationship with other clinics maintained by the Hospital, such as the obstetrics/gynecology clinic ("ob/gyn clinic"). Thus, if patients leave our care for that of the ob/gyn clinic, they will be referred back to us.

12. If a DFPP patient is pregnant, our physician or nurse will inform her, tell her the expected due date and will ask her how she would like to proceed. If she wants to carry her pregnancy to term, our staff will refer her to the community health centers or to local hospitals. If she is interested in the Hospital's ob/gyn clinic, she will be given their telephone number and our staff may even make an appointment for her.

13. If a pregnant patient requests information about abortions and abortion providers, our physician or nurse will provide her with a referral sheet listing various

abortion providers. Each of the providers listed on our referral sheet provides counseling. Our staff will discuss with her the questions she should ask the abortion providers that she calls, such as the cost and method of payment and the ability to obtain an early appointment. Our staff will also inform the patient that other abortion providers are listed in the telephone book if she wants to explore other resources.

14. If a DFPP patient suffers from a medical condition that may be aggravated by the continuation of a pregnancy, that patient is so advised. Such information permits the patient to make an informed decision regarding her pregnancy without unduly delaying in making that decision.

B. Impact of the New Regulations

15. As previously stated, DFPP serves predominantly young, low income, minority women who have no other source of subsidized reproductive health care. The new regulations will severely jeopardize our ability to provide these women with quality, compassionate reproductive health care. They target women who are already the victims of poverty and who traditionally have poor access to the health care system. This will result in a second class health care system for women who are already too often treated as second class citizens.

16. The new regulations require us to advocate childbearing to our clients, irrespective of their health, or emotional state. They prevent our staff from making referrals for all options.

17. By prohibiting us from counseling a woman

about abortion even if she is at medical risk as discussed in paragraph 14, supra, the regulations, if followed, will force us to expose our patients to serious health dangers. Moreover, they subject DFPP to potential liability from failing to obtain informed consent from the patient and from failing to conform to accepted standards of health care.

18. DFPP's physicians are extremely concerned by defendants' attempts to regulate their private patient/doctor relationship and to force them to commit what they consider to be malpractice. DFPP may therefore be forced to withdraw from the Title X program altogether. Our withdrawal from the Title X program can only hurt the patients we serve as it would mean that we would no longer be able to offer those low income women who are ineligible for medicaid the sliding fee scale we offer currently with the use of Title X funds.

19. DFPP's regulation depends upon establishing a relationship of trust with our high risk population. This relationship can only be established if we are perceived as providing quality, comprehensive care to our patients. Once the nature and scope of the information we provide is restricted, the trust our patients have in our ability to provide quality services is undermined. Indeed, adherence to the regulations will most likely make our patients angry and will greatly diminish our relations [with] the community. Fewer women will rely on our services and more unplanned, unwanted pregnancies will result.

Conclusion

For the foregoing reasons, I respectfully submit that plaintiff's motion be granted.

/s/
KATHLEEN MURRAY

Sworn to before me this
16th day of Dec., 1987

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

THE STATE OF NEW YORK, ET AL.,

Plaintiffs,

- against -

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Defendant.

AFFIDAVIT

LINDA RANDOLPH, M.D. M.P.H., being duly sworn, deposes and says:

1. I am the Director of the Office of Public Health of the New York State Department of Health ("NYSDOH") which includes the Bureau of Reproductive Health. Besides an M.D., I have a Masters in Public Health degree in Maternal and Child Health. I submit this affidavit in support of plaintiffs-appellants' motion for an injunction against enforcement of the regulations at issue, 42 CFR 59.8 through 59.10, pending review by the United States Supreme Court.

2. On September 29, 1989 NYSDOH received a Notice of Grant Award from the Department of Health and Human Services ("DHHS") in the amount of $5,817,471 for the budget period July 1, 1989 through

June 30, 1990. The Notice specifically states that the grant is made subject to the grantee providing assurances to DHHS of its intent to provide services in compliance with the regulations within twenty days after a ruling upholding the regulations by the United States Court of Appeals for the Second Circuit. I understand that the time within which NYSDOH has to notify DHHS of its compliance or noncompliance with the requirements of 42 CFR 59.8 through 59.10 has since been extended to December 1.

3. Complying with the regulations would run counter to NYSDOH's standards of acceptable medical practice by effectively denying low- and moderate-income women information they need to make informed decisions about their reproductive health care. Carrying out the requirements of 42 CFR 59.8-59.10 would violate New York State's policy that medical service "of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health." See N.Y.S. Public Health Law § 2800. Implementation of the regulations at issue would force medical professionals to violate state codes of professional conduct; see N.Y.S. Education Law §§ 6506-6509, 8 NYCRR 29.2; and render them liable for malpractice for failing to give full informed consent. See N.Y.S. Public Health Law § 2805-d(1).

4. The NYSDOH Title X Project grant currently funds 37 delegate agencies throughout New York State. Of those 37 agencies, 27 are protected under injunctions issued in Massachusetts v. Bowen or Planned Parenthood Federation of America v. Bowen, either because they are members of the National Family Planning and Reproductive Health Association ("NFPRHA") or because they are Planned Parenthood affiliates. Those 27 agencies will

continue to receive funding under the Grant Award issued on September 29, 1989 until such time as one or both of those injunctions are lifted.

5. The remaining ten delegate agencies receiving Title X funds through NYSDOH, however, face the imminent loss of their funding if this Court does not grant an injunction pending review by the United States Supreme Court and they determine they are not able to comply with the regulations. The ten affected projects are: Greene County Family Planning Service, Harlem Hospital, Livingston County Health Department, Middletown Community Health Care Center, Nassau County Health Department, Suffolk County Health Department, Threshold Center for Alternative Youth Services, Westchester County Health Department, Family Life Information Center and Westchester/Rockland Planned Parenthood. The affected projects, their Title X funding allocations, other budgetary details, and the numbers of clients served are listed below:

	Total Budget	Total NYS Grant	Total Title X Grant	Number of Sites	Number of Clients
Greene	$ 191,823	$ 86,798	$ 36,310	1	1,002
Harlem	996,857	378,195	245,840	1	6,776
Livingston	417,844	191,222	28,338	2	1,878
Middletown	233,123	124,187	21,655	2	2,045
Nassau	1,002,164	395,771	126,303	4	5,111
Suffolk	1,983,660	724,051	244,224	12	5,653
Threshold	599,504	186,608	126,140	1	2,382
Westchester HD	588,876	263,909	149,661	4	2,111
FLIC	88,862	60,900	15,870	1	123
West/Rock PP	2,434,969	693,203	204,233	9	11,360
TOTAL	$8,537,702 (100.0)	$3,105,474 (36.4)	$1,238,584 (14.5)	37	41,408

6. Title X funds represent a significant resource to the New York State Family Planning program; the $5,817,471 awarded for 1989-90 represents 24.8 percent of the total program funding of $23,489,837. Title X funds are particularly important to the projects listed above. Title X funds represent just under 40 percent of the total New York State Family Planning Program grant fund provided to those agencies and they account for 14.5 percent of the projects' total operating budgets.

7. In 1988, these ten projects provided comprehensive high quality family planning services to a total of 41,408 clients; 32,095 or 77.5 percent of which had incomes below 200 percent of the federal poverty level, 14,031 or 33.9 percent of whom were racial minorities, and 11,328 or 27.4 percent of whom were teenagers. Loss of Title X funding will have a major impact on these populations. All affected projects service areas with economically disadvantaged populations at risk for adverse pregnancy outcomes. New York State has made considerable effort to ensure that such areas are targeted for family planning programs, and loss of Title X funds will mean service loss at least in proportion to the amount of Title X funds lost. Discussion of the anticipated impact of Title X funding losses on selected projects and their service area population follows:

Harlem Hospital Family Planning Program

8. This institution serves the Central Harlem area of Manhattan, without question the highest risk area of New York State for adverse outcomes of pregnancy. In 1986, eight out of every ten babies born to Central Harlem residents were born out-of-wedlock, and the incidence rates of low birth weight (19.0%) and infant

mortality (27.6/1000 live births) were twice and three times that of New York City as a whole, respectively.

9. In 1988, the project provided care to 6,776 clients who made 11,097 visits. Nearly all clients (97.6%) had family incomes below 150% of the Federal Poverty level, and 5194, or 76.7% were black women. Teens comprised 1468, or 21.7 percent, of total clients.

10. Title X funds awarded for the 1989-90 program year amount to $245,840, or 24.7 percent of the project's total budget. A loss of this magnitude will force major reductions in clinic hours and staffing, and concomitant reductions in the service capacity of the project. Without Title X funding, it is estimated that 1200 fewer clients will be served over the next year. There are no alternate public providers of family planning services for the residents of Central Harlem, and loss of Title X funding could threaten the viability of the entire project.

Westchester County Department of Health/Westchester Rockland Planned Parenthood

11. These two projects serve residents of two major counties in the New York City metropolitan area. The areas served by these projects are among the highest risk areas of New York State, as demonstrated by the accompanying maps. In 1988, these agencies served 13,471 clients, most of whom were women residing in the high risk communities - Yonkers, Mt. Vernon, New Rochelle, White Plains, Portchester, Peekskill and Ossining in Westchester County; and West Nyack, Nyack and Haverstraw in Rockland County.

12. Loss of Title X funding, which totals $353,894 for the 1989-1990 program year, will mean that some

2,020 fewer women at risk for unintended pregnancy will be served in the coming year. This loss is especially critical since there are no publicly-subsidized family planning services in the majority of areas served by affected project sites. In Westchester County, only Peekskill and Ossining have suitable alternative resources, while in Rockland there are no alternatives available. Even in Peekskill and Ossining, however, it will take months to develop the capacity to meet increased service volume needs.

Nassau County Health Department/Suffolk County Health Department

13. These agencies provide care to residents of the two most populous counties, outside of New York City, in the State. Although both are prosperous counties, they provide services to significant pockets of population characterized by economic deprivation and poor health status. The family planning project sites operated by these agencies provided care to 10,764 clients in 1988. With an anticipated loss of $370,000, or 12.4 percent of their total project budgets, it is estimated that 1335 fewer clients will be served in the coming year.

14. Although both counties are served by Planned Parenthood organizations, only 3 of 12 areas served by Suffolk County Health Department are also served by Planned Parenthood sites, and none of four Nassau County Health Department clinic sites have Planned Pare[n]thood sites in reasonable proximity. In any event, neither of the Planned Parenthood agencies has the capacity to absorb a large number of new clients, and it would require at least six months to develop the staffing and clinic space needed to accommodate them.

Threshold

15. This project is unique in that it provides comprehensive health, social support and education services to a young, largely teenaged population. Family planning services are offered as one element in a comprehensive service environment. The agency's Title X award was $126,140 for the 1989-1990 program year, an amount that represents 21.0 percent of its total budget.

16. In 1988, this agency provided family planning care to 2382 young people, of whom 1362, or 57.2 percent, were teenagers and 841, or 40.0 percent, were members of racial minority groups. Loss of Title X funding will mean staffing and service reductions such that 420 fewer clients will be served in the coming year.

17. Because this agency cannot obtain third-party reimbursement for many of the services it provides, it is highly reliant on categorical grant funds for survival. In its current vulnerable financial condition, a funding cut[] of this magnitude could threaten its viability. It is conceivable, then, that total service loss could occur.

18. Downtown Rochester is served by Planned Parenthood of Rochester. Although some teens now served by Threshold might access Planned Parenthood services, most will probably not. Most Threshold clients come not for family planning services, but for a variety of social service-related reasons. During the course of counseling, the teens will acknowledge their needs for family planning services and it is then that care is provided. Important school outreach and counseling programs supported by the grant will be discontinued, thus further undermining the case finding and community

education function of the agency.

Conclusion

19. In summary, the loss of Title X funds for any of the affected agencies who determine that they cannot comply will have a major effect on the ability of NYSDOH to meet its mission of enabling high risk low-income women to obtain high quality comprehensive family planning services. If all of the affected agencies decide they cannot comply, an estimated 6200 women will be unable to obtain services in the next year if loss of funding occurs; if only half experience an unintended pregnancy, and their outcomes approximate those of New York City residents age 20-24, a total of 843 additional out-of-wedlock births and 1498 additional abortions will occur among New York State residents. The cost of such events, whether appraised in human or economic terms, will surely surpass whatever benefits might accrue to the federal government in implementing the regulations immediately. Even if the affected agencies comply with the requirements, their clients will suffer because they will be unable to make decisions and obtain medical services with full knowledge of available alternatives.

For the reasons set forth above, I respectfully submit that this Court enjoin enforcement of the regulations in New York State, pending review by the United States Supreme Court.

/s/
LINDA RANDOLPH, M.D., M.P.H.

Sworn to before me this
13th day of November, 1989

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	DECLARATION 88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

IRVING RUST, M.D. deposes and says the following:

1. I am the Medical Director of the Bronx Center of Planned Parenthood of New York City, Inc. ("PPNYC"), a Title X grantee. I am a physician licensed to practice medicine in the State of New York and have practiced in the field of family planning for 20 years. I have been medical director of the Bronx Center since 1977, and am also currently medical director of the Community Family Planning Council of New York City. A copy of my resume is attached as Exhibit A.

2. This declaration is submitted to document the irreparable harm that will occur should Plaintiffs' Motion for a Preliminary Injunction not be granted. I raise the injuries the regulations inflict on my right to practice

medicine, and demonstrate how they endanger the life and health of my Title X patients. This declaration is also made on behalf of the class I represent: health professionals in Title X facilities in New York State.

3. Based upon my extensive experience with providing reproductive health care to low-income women, I believe that the new regulations would expose health professionals to liability, undermine the integrity of our medical facility, violate our patient's rights, and harm their health. If we do not obey them, however, we will lose our Title X grant, which will mean a serious cutback in the essential health services we provide to the South Bronx community. Because the regulations are so irreparably harmful, PPNYC cannot obey them. (See Declaration of PPNYC executive director Alfred Moran).

4. The Bronx Center and its self-contained comprehensive health unit for teenagers called the HUB provides comprehensive reproductive health services including health education, counseling, preparation of a detailed medical history, testing for a variety of diseases and disorders including sexually transmitted disease, dispensation of contraception, pregnancy testing, genetic counseling, amniocentesis referral for at-risk pregnant patients, prenatal care, abortion counseling and referral and, if desired, first trimester abortion services. The Bronx Center is an Article 28 state licensed diagnostic and treatment center.

5. The Bronx Center is the major provider of reproductive health services in the South Bronx. In 1986, it provided family planning services alone to 7,138 patients. Between 95 and 97% of the Bronx Center's patients are Black or Hispanic and 40% of its family planning patients are adolescents. Eighty percent of the

Center's patients are either Medicaid eligible or below federal poverty standards.

6. The Bronx Center received $439,391 in Title X funds in fiscal 1987. This grant comprised 20% of its total budget, and 50% of its family planning budget.

7. The services provided by the Bronx Center are of immeasurable value to the South Bronx community. The South Bronx has one of the highest rates of teen pregnancy and infant mortality in the state. The Bronx Center, and the HUB in particular, has specifically targeted these two problems through the provision of early prenatal care and the implementation of special programs for teens. The HUB, a program in existence at the Bronx Center since 1982, provides special comprehensive health care for teenagers and their families and is designed to help them avoid premature and unwanted pregnancy. In addition to its family planning services for adults and teens, it also provides various educational, counseling and recreational programs which seek to address the problems and concerns of the community's teens.

8. Physicians at the Bronx Center perform approximately 2,000 first trimester abortions per year. Second trimester abortions are referred to licensed providers. Most of our abortion services are paid for under New York State Medicaid. No Title X funds are used to subsidize the performance of abortions.

9. Because the new regulations prohibit any form of counseling or information about abortion, even following a diagnosis of pregnancy, if we complied with the new regulations our patients would be exposed to serious physical and mental harm in a variety of situations.

a. Access to information about abortion is essential to the ability of a non-pregnant patient to give informed consent to her choice of contraceptive method. For many patients with diabetes, heart disease, or hypertension, oral contraceptives may present a serious health risk. It is imperative that I inform these patients that use of a diaphragm with the back-up of an early abortion is in fact the safest method of contraception,[17] despite the lower effectiveness rate of the diaphragm versus the pill.

b. No responsible family planning decision can be made without information about every alternative available, including that of abortion, in the event that contraceptive failure occurs. Restrictions on such information are particularly harmful to my Bronx patients because most of them have no other source of information about family planning.

c. All family planning patients need to be told that they must take an early pregnancy test if they think they are pregnant whether or not they choose to terminate their pregnancy or to carry to term. Early abortion is an extremely safe medical procedure; the medical risks of abortion increase as pregnancy progresses. Under the new regulations patients could no longer be informed of this fact.

d. Pregnant patients[] cannot make voluntary

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[17] See Tietze, Bongaarts & Schearer, "Mortality Associated with the Control of Fertility," 8 Family Planning Perspectives (Jan/Feb 1976).

medical decisions in an environment where physicians must actively promote childbirth by forcing prenatal care information, even on those women who have decided to terminate their pregnancies.

e. It is my understanding that under the proposed regulations neither my co-workers nor I will be able to offer proper follow-up counseling to our pregnant patients who have been referred for genetic testing. Counseling is essential for any patient who receives test results indicating that she or her fetus is at risk, and I cannot provide such counseling without discussing the option of abortion if I am to comport with the standards of the medical community and with professional ethics.

10. If I cannot refer my patients for an abortion they will have difficulty locating appropriate abortion services. Those who do locate a provider in time for an abortion will inevitably be delayed. Every week following the eighth week of gestation, increases the risk of abortion morbidity and abortion mortality.

11. Lack of access to licensed medical facilities has been shown not to deter most patients from seeking an abortion. My inability to refer patients to licensed abortion providers would, accordingly, result in an increase in the number of self-abortions and abortions performed under hazardous medical conditions by persons lacking appropriate training rather than an increase in the number of patients carrying to term.

12. Without referrals to licensed abortion facilities, some patients will obtain abortions from providers who

offer second class abortions and post-abortion care. For instance, when it is determined after a blood test that a pregnant patient at the Bronx Center has RH negative (RH-) blood, and her fetus has RH positive (RH+) blood, she is given a Rhogan injection as part of her follow up abortion care. This injection is necessary to prevent complications in future pregnancies by ensuring that the patient does not build up antibodies to RH+ blood. Many non-licensed facilities will not provide this type of follow up treatment. I prefer to refer patients to facilities in which I know they will receive the highest quality care.

13. A minority of uninformed patients could not pursue the option of abortion; others will delay until a stage of pregnancy when the abortion is impossible or too difficult to obtain. The resulting increase in forced motherhood will create heavy social and economic costs, particularly when the mother is an adolescent.

14. Prior to Roe v. Wade I treated countless patients who had attempted self-abortion or who had abortions performed by persons with limited experience. Some women arrived at the hospital with catheters lodged in the uterus and protruding from the vagina. Others douched with a variety of hazardous chemicals, which in many cases caused permanent damage to their vaginal walls. Most often, women arrived who had undergone septic, incomplete abortions. When women are denied information about where to obtain safe abortions from licensed facilities, the likelihood of such incidents occurring again increases.

15. The need for the dissemination of abortion information in the South Bronx community is illustrated by one of my patients who tried to abort herself by

taking Humphrey's II, an over-the-counter drug which has been reputed to cause early abortion by inducing bleeding. While the drug itself is not dangerous, it will induce bleeding and may cause a partial abortion in a pregnant patient, which can seriously endanger her reproductive health. After treating the patient, I asked her why she had endangered her health when she could have obtained a safe and legal abortion. She responded that she didn't know that she could obtain an abortion, or where information about abortions was available. This incident points out the continuing need to disseminate information about the availability of abortion to the Bronx Center's community.

16. In addition to attempts at self-abortion, failure to counsel patients with an unwanted pregnancy, especially in conjunction with the mandatory dissemination of information on prenatal care, would impose additional harm to many patients, particularly adolescents. Such harm would include an increase in teen runaways and teen suicide. Many adolescents whom I diagnose as pregnant suffer from feelings of isolation, panic and fear. Immediate counseling is necessary to quell these feelings and to present these teens with unbiased information about their options. HUB counselors are often instrumental in convincing reluctant adolescents to discuss their pregnancy and the options available to them with their parents or other adult family members.

17. There are distinct and additional harms to the lives and health of my patients for whom an abortion is medically indicated.

a. Without proper abortion counseling and referral my pregnant patients with AIDS, epilepsy, severe diabetes, hypertension, congenital

heart disease or cancer may suffer serious injury or even death. One in 43 babies tested for AIDS in the Bronx are found to carry the AIDS virus. This is the highest figure of AIDS births in New York State. A pregnant patient with AIDS must be told of the risks to her health and to the health of her child. She should also be told about the abortion option. Some of my patients have sickle cell disease; these women have a 25% chance of going into sickle cell crisis and dying as a result of pregnancy. Those of my patients with such conditions must be counseled immediately about the risks involved in carrying their pregnancy to term. If a diabetic patient whose blood sugar fluctuates greatly is diagnosed as pregnant, I must inform that patient of the possibility that she may go into diabetic coma or insulin coma, as a result of the additional stress the fetus places on her system. I am also obliged to tell that patient that the fetus may die at any point in the pregnancy. Because such conditions do not clearly constitute "emergencies" under the proposed regulations, I could not provide such essential counseling but instead would be required to give the patients information on prenatal care, thus steering these women toward the serious health risk of carrying to term.

b. Any pregnant patient with a serious medical condition who wishes to continue her pregnancy is a high risk patient and must be referred to a high risk clinic. The list of prenatal care and delivery services required by the regulations would not be sufficient. Such a patient must be told of the seriousness of her

condition, the threat to her life and to the life of the fetus, and must be immediately referred to a high risk clinic. This referral may include making an appointment for enrollment in a pre-natal program for high risk patients.

18. Requiring that Title X-funded clinics physically segregate family planning programs from abortion services and abortion-related activities would also be harmful to my patients, and would undercut the provision of comprehensive health care currently provided at the Bronx Center. Particularly where teens are involved, integrated services are needed to facilitate enrollment in counseling and family planning programs. Many of our patients first visit the clinic for pregnancy testing or abortion services although they may need counseling, family planning or prenatal care. Because of the proximity of services and personnel, we are able to immediately channel a patient into a program which meets her needs. For example, post abortion patients are immediately enrolled in the Bronx Center's family planning program on the same premises, where after counseling and discussion with a staff health professional, they select a contraceptive method. Prompt enrollment in a family planning program is essential for post abortion patients to prevent future unplanned or unwanted pregnancy, and to encourage a responsible attitude toward sex and reproductive health. Post abortion adolescents are also referred to the counseling program of the HUB. Prompt and successful enrollment of patients in counseling, family planning and pre-natal programs would be impossible if the services were provided on different sites from abortion and abortion-related services. Moreover, making two trips to different locations would often be expensive and difficult for my patients.

19. The detrimental programmatic and financial impact caused by the segregation requirements would be exacerbated by the failure of the new regulations to explain how compliance may be achieved. The regulations expressly state that the list of relevant factors provided is not exhaustive; the evaluation of a Title X clinic's attempt to comply lies wholly within the discretion of HHS. Because of the onerous nature of the separation requirements and the fact that Title X health care providers cannot accurately assess how to comply, rapid judicial assessment of the legality of the new regulations is crucial to the survival of the Bronx Center's family planning program.

20. Compliance with the new regulations would make it impossible for me to practice conscientious medicine. Compliance would expose my colleagues at the Bronx Center and me to the risk of legal liability as well as professional censure.

a. By failing to provide complete referrals and information to patients, I would be violating New York law requiring health care professionals to provide a pregnant women with "sufficient information concerning her condition and alternatives so that she can reasonably decide whether she [is] willing to undergo the entire pregnancy and deliver the child or abort the pregnancy. Becker v. Schwartz 60 A.D. 2d 587 (2d Dept. 1977) modified on other grounds, 46 N.Y. 2d 401, (1978). See also Rivera v. State of New York 94 Misc. 2d 157, 404 N.Y.S. 2d 950, 953 (Ct. Cl. 1978).

b. Recent amendments to the New York State Department of Health's regulations

require that all diagnostic and treatment centers provide patients with referrals "to other providers of health services as indicated by the patient's needs and documented in the patient's medical record.["][18] Compliance with the new Title X regulations would force me to violate this law and expose the Bronx Center to loss of its license and its status as a Medicaid provider.

c. The new Title X regulations would force me to violate basic principles of medical ethics. There are very few circumstances in which a physician may withhold information from a patient about available and safe medical options to treat the patient's medical condition. In almost all cases, everything that is of importance to the patient with regard to her health must be discussed and disclosed. Although no clinician should refuse to provide a woman with services or referrals which would aid her in obtaining optimal medical care, the new regulations would force me and my staff to violate this moral, ethical, and legal duty so long as the HUB received Title X funds.[19]

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[18] 10 N.Y.C.R.R. 753.1(b) (1987).

[19] For example, the American Medical Association ("AMA") authorizes physicians to make referrals to any ". . . provider of health care services permitted by law to furnish such services." The AMA also enumerates only two instances in which physicians may withhold health information from patients -- when the patient is unconscious or "when risk-disclosure poses a serious psychological threat" to the patient. Current Opinions of the Judicial Council of the American Medical Association, 1984. The American College of Obstetricians and Gynecologists requires that:

(continued...)

21. For the foregoing reasons, based on my expertise in the field of reproductive medicine, I believe that the new Title X regulations, if implemented, would result in irreparable harm to indigent women and teens, and would undermine the integrity and the quality of services provided by the HUB Center. The loss of the Title X grant, on the other hand, would decimate the services provided by the Bronx Center, since Title X funds make up 50% of our family planning budget. In a community which has one of the highest infant and maternal mortality rates in New York City, and which has an unemployment rate double the national average, the harm which would result from the loss of an established comprehensive health care facility such as the Bronx Center is inestimable.

WHEREFORE, I respectfully request that the Court grant plaintiff's Motion for a Preliminary Injunction.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 2/5/88 /s/
Irving Rust, M. D.

[Exhibit omitted.]

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[19] (...continued)

> In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy.

American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services (1985).

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	AFFIDAVIT
		88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

AFFIDAVIT OF JAMES H. SAMMONS, M.D.

James H. Sammons, M.D., being first duly sworn on oath, deposes and states as follows:

1. I am a physician and the Executive Vice President of the American Medical Association ("AMA"). I am submitting this affidavit on behalf of the AMA in support of Plaintiffs' Motion for a Preliminary Injunction enjoining implementation of new regulations promulgated by the United States Department of Health and Human Services ("HHS") under Title X of the Public Health Service Act ("TITLE X"). 53 Fed. Reg. 2922 et seq. (Feb. 2, 1988). On February 10, 1988, the Board of Directors of the AMA officially authorized the participation of the AMA in legal action to oppose the implementation of these regulations.

2. The AMA is a voluntary nonprofit organization of more than 280,000 physicians and medical students dedicated to promoting the public welfare through the maintenance of the highest professional standards and the provision of quality medical care. In order to achieve these goals, the AMA is committed to preserving the freedom of patients to seek and obtain needed medical care. Concomitantly, physicians must be free to discharge their professional responsibility to provide care and treatment appropriate for the individual patient, according to their best clinical judgment consistent with medical standards.

3. To further these ends, the AMA believes that physicians must be free to disclose to their patients the full spectrum of information and options necessary for informed medical decision making. The "Principles of Medical Ethics" promulgated by the AMA, as elaborated upon in the Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1986) specifically acknowledge that:

> "The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. They physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."

Opinion 8.07. Thus, every physician has an ethical and professional duty to provide a patient with enough information so that she can make an informed decision as to her medical care.

4. In the opinion of the AMA, the regulations at issue in this case will interfere with the ability of those physicians who happen to be in Title X-funded programs to exercise their best judgment in the manner most responsive to and appropriate for the individual patient's health needs. They will prevent a frank discussion of medical information and artificially constrict the physician-patient dialogue in ways that are inconsistent with sound medical care.

5. In order to understand how these regulations threaten to impair the physician-patient relationship, it is important to recognize that family planning decisions may have critical medical implications. In fact, decisions made in the context of family planning can affect the future life and health of a woman and the fetus she may be carrying.

6. In fact, HHS previously has recognized the inextricably medical nature of family planning services. Until now, Title X programs were required to offer comprehensive "nondirective" counseling to their patients, both nonpregnant and pregnant. These family planning services include medical exams, medical testing for pregnancy or disease, counseling with respect to potential health risks and benefits of contraceptive alternatives or of pregnancy itself, and referrals to other medical providers when indicated or requested. This wide range of information and services was provided so as to ensure that family planning decisions were made on a medically informed basis. Physicians were free to provide medical

advice, in conformance with professional standards of medical care and ethics, and to be responsive to the needs and requests of individual patients.

7. The new regulations, however, restrict the substantive scope of medical counseling that a physician may provide to his or her patients. For example, under the new regulations, once it has been determined that a patient is pregnant, i.e., as a result of a medical exam performed at a family planning clinic, a physician may not counsel or refer with respect to pregnancy termination, even if the pregnancy poses a threat to the woman's life or health and pregnancy termination is an option that the physician, in his or her medical judgment, normally would discuss with the patient at that time. Rather, the woman "must be referred for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of mother and unborn child." 53 Fed. Reg. 2945 (to be codified at 42 CFR § 59.8(a)(2)). Moreover, the physician must also provide the pregnant woman "with information necessary to protect the health of mother and unborn child until such time as the referral appointment is kept." Id. HHS has commented that "acceptable" information would relate to "good health practices during pregnancy" and could not include the possibility of pregnancy termination. 53 Fed. Reg. 2937.

8. Accordingly, these regulations will directly interfere with the ability of physicians in Title X-funded programs to discharge their professional responsibilities and provide their pregnant patients with what is considered to be necessary and appropriate medical information and counseling. Indeed, the AMA is deeply concerned that these regulations will endanger the lives and health of women with medical conditions which may

be exacerbated by pregnancy. Under the new regulations, a woman with a condition such as AIDS, diabetes, hypertension, heart disease, renal disease, sickle cell anemia, or cancer will be deprived of necessary counseling and information -- e.g., that she faces serious health risks as a result of her pregnancy. Professional standards of care require, however, that physicians be free to apprise these women of the seriousness of their condition, and the potential threat to their lives and health. Physicians must be able to exercise their best medical judgment and provide full disclosure of the health hazards that continuation of pregnancy may pose for these women and of all the available medical alternatives. Physicians must be allowed to engage in the frank physician-patient discussions that will permit a patient to choose the appropriate course for herself.

9. Under the new regulations, however, physicians in Title X-funded clinics will not be permitted to provide this information or these vital discussions, despite the fact that continuing the pregnancy may threaten the patient's life or health and even if the patient specifically inquires about the potential medical consequences of her pregnancy. Such limitations on the physician-patient dialogue have heretofore been unknown, and constitute an unacceptable intrusion into the physician-patient relationship.

10. By the same token, certain maternal disorders greatly increase perinatal mortality and morbidity and may require discussion of pregnancy termination as an option pursuant to providing full disclosure of medical information. For example, congenital abnormalities occur two to three times more often among children of diabetic women, and the abnormalities associated with prenatal diabetes are more severe and more often

multiple and fatal. Cousins, Congenital Anomalies Among Infants of Diabetic Mothers, 147 Am. J. Obstet. & Gynecol. 333 (1983). Similarly, a pregnant woman may be infected with a disease such as AIDS, rubella, herpes, cytomegalovirus or toxoplasmosis, that could have devastating effects on her fetus. Consider the child who has been exposed to a rubella infection during the first four weeks of gestation. This child has a 61% chance of developing congenital defects, including ocular and cardiovascular anomalies, deafness, mental retardation, and early onset diabetes. Simpson et al., Genetics in Obstetrics and Gynecology 229-30 (1982). The AMA strongly believes that a physician should be free to counsel a pregnant woman as to the serious threat that her medical condition poses to her fetus. A physician must have the ability to inform the woman, if appropriate in the circumstances of the patient's medical situation and inquiries, that pregnancy termination may be an option. The new regulations, however, will forbid the provision of this information even if the pregnant woman inquires about her medical condition and the effect it might have on her fetus.

11. In addition, some pregnant women may be at high risk of delivering a child with a severe genetic disorder. This group includes women of advanced maternal age (over 35) who are at an increased risk of having a child with a chromosomal abnormality such as Down's syndrome; women in couples, both of whom are members of a high risk ethnic group such as Ashkenazi Jewish couples who are at high risk of having a child with Tay-Sachs Disease; women who previously had a child with a genetic disorder such as polycystic kidney disease; and women who have a history of multifactorial disorders such as anencephaly in their families. See generally, Milunsky, Genetic Disorders and the Fetus (2d

ed. 1986). Professionally established standards of medical care require that physicians be free to inform a patient if she is at an increased risk of having an impaired child and alert her to the availability of prenatal testing and the option of pregnancy termination. The new regulations, however, will forbid this free flow of medical information. Thus, they will deny many women the option of making an informed choice not to carry and deliver a child with a severe and often fatal birth defect.

12. Moreover, any delay in receiving necessary medical counseling and referral information may in and of itself pose serious risks. If a woman with a high risk pregnancy is not told about the availability of prenatal diagnostic procedures, for example, she may terminate her pregnancy simply out of fear of having a severely affected child. Further, if pregnancy termination is necessary, it will be a much safer procedure for the woman if it is [per]formed early in pregnancy.

13. These are merely examples of the variety of medical circumstances in which a physician must be free to mention or discuss the possibility of pregnancy termination, in the interests of providing sound medical care. However, a physician in a Title X-funded clinic will not be able to disclose or discuss pregnancy termination with a patient, even when the patient specifically asks about the medical advisability of such procedure. Instead the physician will be required, regardless of how inappropriate under the circumstances, to inform the woman about "good health practices during pregnancy" and to provide her with an undifferentiated list of health care providers that is designed to minimize the availability of the very procedure which, in any other situation, the physician might explicitly recommend or

make referral for. See 53 Fed. Reg. 2937. The AMA is concerned that these mandatory and inflexible rules for disclosure and nondisclosure will severely limit the free flow of vital medical information that is necessary for the provision of optimal care, and will undermine the physician-patient relationship.

14. Physicians in Title X-funded clinics also will be prohibited from providing appropriate medical information to their nonpregnant patients. As stated earlier, for some women pregnancy may constitute a threat to continued life and health. For a woman with severe hypertension, for example, reliable forms of contraception such as the pill may be medically contra-indicated and pregnancy may threaten her life. If this woman requests information about the medical implications of her contraception options, a physician in a Title X-funded clinic will be forbidden from discussing the safest alternative for her, i.e., the use of a diaphragm with early pregnancy termination as a backup. Such a failure to disclose the best available medical option violates medical and ethical standards. It also negates any informed consent to contraceptive care.

15. As HHS correctly points out, a physician cannot, and should not, be compelled to perform a medical procedure that violates his or her conscience. 53 Fed. Reg. 2929. A physician must be free, however, in conformance with professional standards of care, to exercise his or her best medical judgment as to the need to disclose the availability of that procedure, even if he or she does not or cannot perform it. A physician must be free to inform a woman about any risks to her health, or to the health of her fetus, that may result from continuation of pregnancy and refer her, if she desires, to another physician for further advice, testing or pregnancy

termination. Medical ethics demand no less.

16. In sum, the AMA is deeply concerned that the new regulations seek to legislate medical practice for physicians in Title X-funded programs irrespective of sound medical practice, the physician's best clinical judgement, and the patient's medical needs and wishes. These regulations will force physicians to give their patients medically incomplete and potentially misleading information and referrals. They will compel them to encourage childbirth for all pregnant patients without regard to their critical medical needs and without counseling or discussion about their individual situations. They will denigrate the integrity of the physician-patient relationship. They will force physicians to violate established standards of medical care and professional ethics, and often their own conscience.

17. For the foregoing reasons, it is the opinion of the AMA that the proposed Title X regulations will cause irreparable harm to patients, especially to the indigent women and adolescents whom the program was designed to serve, and will unacceptably undermine the quality of the services provided by physicians in Title X-funded facilities.

18. The AMA intends to seek leave to intervene as a plaintiff in this lawsuit as soon as time permits. This affidavit is submitted to provide the opinions and concerns of the AMA for the Court's consideration upon Plaintiffs' Motion for a Preliminary Injunction on February 19, 1988.

WHEREFORE, I respectfully request that the Court grant Plaintiffs' Motion for a Preliminary Injunction.

FURTHER AFFIANT SAYETH NOT.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

Executed on: 2-18-88 /s/

James H. Sammons, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	**DECLARATION**
		88 CIV. NO. 0702
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	(LLS)
Defendant.	:	

LORRAINE TIEZZI declares under penalty of perjury as follows:

1. I am the director of the family planning clinics at The Presbyterian Hospital in the City of New York ("Presbyterian Hospital"). I submit this declaration in support of plaintiffs' motion for a temporary restraining order and/or preliminary injunction enjoining implementation of regulations promulgated under Title X of the Public Health Service Act ("Title X"). I also submit this declaration in support of plaintiffs' request for an early hearing date.

2. Presbyterian Hospital is a not-for-profit corporation organiz[ed] under the laws of the State of New York. Presbyterian Hospital provides acute in-patient care and out-patient medical care, including

family planning and abortion services.

3. Presbyterian Hospital provides family planning services for adults and for young adults under 21 years of age. The adult clinic operates five days a week performing pregnancy testing and providing contraceptive services. On three days family planning and reproductive counseling sessions are conducted. The young adult clinic operates two evenings and one afternoon a week and a separate clinic for young men is operated one night a week. The family planning clinics are operated as part of the obstetrics and gynecology clinic at Vanderbilt Clinic of Presbyterian Hospital. The clinic performs the following services: gynecological examinations, provision of contraceptives, cancer screening (including pap smears and breast examinations), and pregnancy testing. Patients are referred to other clinics at Presbyterian Hospital for other medical services, including services relating to pregnancy and infertility.

4. In 1986, Presbyterian Hospital's family planning clinics served approximately 7,400 patients, approximately 2,500 of whom were under twenty-one years old. Fees are charged on a sliding scale and a substantial percentage of the family planning clinics' patients have Medicaid.

5. In 1987, Presbyterian Hospital received a Title X subgrant of $480,247 from the Medical and Health Research Association of New York City, Inc. The only other source of funds for the family planning clinics is from Medicaid. Income received from patients is insignificant. The Title X grant and the Medicaid funds enable the Hospital to provide family planning services for low-income women and young adults.

6. Abortions are performed at Presbyterian Hospital on a separate floor of the same building in which the family planning clinic is located. The family planning clinic and abortion services are both part of the OB-GYN clinic, and thus share the same entrance, and waiting and reception areas. The abortion services and the family planning clinic also share the same patient records, and billing is done through the same office.

7. Pregnant women who come to the family planning clinics are given extensive options counseling. Those who express the desire to terminate their pregnancies are referred to a counselor in the abortion service, who refers the patients to licensed Article 28 clinics and hospitals, including Presbyterian, which perform abortions. Those women who wish to continue their pregnancies are referred to Presbyterian's prenatal clinic.

8. The new Title X regulations would irreparably harm Presbyterian Hospital's family planning program and patients in the following ways:

a. Presbyterian's family planning clinics serve a primarily low-income, immigrant population in the Washington Heights section of Manhattan. The vast majority of these people use Presbyterian Hospital as their primary care facility, i.e., they do not have and can not afford private doctors. Washington Heights and the surrounding areas where patients of the clinic reside, are underserved by private doctors. There is no other facility in the Washington Heights area which provides these kinds of family planning services and counseling,

and the patients the Hospital serves are unlikely to go elsewhere in New York City to obtain family planning services. Thus the curtailment of options counseling, which is compelled by the new regulations, would irreparably harm the patients the Hospital serves because they would get inadequate and incomplete counseling to make reasoned and informed judgments about whether to continue or terminate their pregnancies. In particular, the young adults who come to the family planning clinic are unsure about whether to carry their pregnancy to term or to terminate the pregnancy. The Hospital's counselors, social workers, and physicians explain all of the options, including childbirth, life planning, adoption, and abortion. Patients for whom abortion is medically necessary could suffer irreparable physic[al] and mental harm, or in extreme cases, death, if they were not informed of the abortion option. Thus, the ability to provide comprehensive medical care to low-income women and young adults would be directly impaired by the new regulations.

b. Presbyterian Hospital serves patients with medical problems, including diabetes, cancer, AIDS, and IUD failure. Under the new regulations, the medical ethical standards of physicians and other professional staff at Presbyterian's family planning clinics may be called into question should they have to refuse to counsel pregnant patients for whom an

abortion may be medically indicated. If the professional staff were precluded by the new regulations from counseling high risk pregnant patients about the dangers to both the mother and the fetus of continuation of pregnancy, they could be subject to legal claims based upon lack of informed consent.

c. As written, the new regulations mandate that any woman who is found to be pregnant must be referred to a prenatal clinic. Thus, physicians, nurses, and counselors in the family planning clinics would be prohibited from answering any of the pregnant patient's questions about family planning or abortion. This makes the provision of continuous, comprehensive care tailored to the individual patient's needs nearly impossible. Furthermore, this places medical professionals in a clear dilemma regarding their professional ethics, which require that full information be given to patients. Medical professionals who find their ethical standards compromised by the new regulations may cease working for the family planning clinics.

d. The new regulations also require physicians to provide prenatal care information to every pregnant patient. In such an environment of pressure toward the option of carrying to term, it is extremely difficult for a patient to make a truly voluntary family planning decision.

e. Presbyterian Hospital may have to redesign or relocate its family planning clinics, because of the requirement that personnel, equipment, and physical location of abortion services be physically separated from the Title X-funded family planning services. Such separation would not likely be financially or practically feasible for the Hospital.

f. When a counselor is prohibited from answering questions by pregnant and non-pregnant women about abortion, the relationship of trust and confidence that has been built up may be irreparably damaged. Low-income women and young adults will probably suffer an increase in unwanted pregnancy and continued ignorance about their legal and medical options. Moreover, this failure to provide complete, truthful, non-judgmental information would create a serious loss, particularly for Presbyterian's young adult patients, who have had a limited and often inaccurate education about sexual matters, and who are often unsure and afraid when they come to the clinic and are seeking counseling and information as to all possible options.

9. Presbyterian Hospital has the option of relinquishing Title X funds or drastically redesigning the services currently offered at the family planning clinic to comply with the new regulations. However, the first option would likely mean elimination of the program, because Title X funds provide approximately 75% of the

program's funds, and the women and young adults who utilize the Hospital's services would be financially unable to pay the fees that would have to be charged to continue the operation of the program. Thus, if Presbyterian Hospital did not receive Title X funds it is likely that the family planning clinics could no longer operate because the Hospital does not have other funds available for this program. Choosing the second option would result in the exclusion of essential services vital to the indigent women and young adults who utilize Presbyterian as their primary health care provider. The difficulty of this decision and the time necessary to implement either choice makes a rapid determination of the legality of the new regulations extremely important.

10. Implementation of the new Title X regulations would irreparably harm Presbyterian Hospital's program and the patients the Hospital serves. These regulations will deny the Hospital's patients the ability to make informed choices and will expose pregnant patients to both physical and psychological risks, by prohibiting all counseling for pregnant patients, and prohibiting abortion referrals for patients who require such services.

WHEREFORE, I respectfully request that the Court grant plaintiffs' Motion for a temporary restraining order and/or preliminary injunction.

Executed on February 4, 1988

/s/
Lorraine Tiezzi

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DR. IRVING RUST, ET AL.,	:	
Plaintiffs,	:	
- against -	:	
		AFFIDAVIT
OTIS BOWEN, or his successor, Secretary of the United States Department of Health and Human Services,	:	
Defendant.	:	

State of New York)
) ss:
County of New York)

Michaele P. White, being duly sworn, deposes and says:

1. I am the Administrator of Health Resources of The DOOR - A Center of Alternatives, and I submit this Affidavit in support of the Plaintiffs' Motion for a Preliminary Injunction. My Curriculum Vitae is attached hereto as Exhibit A. As set forth in more detail below, any interference with the provision of comprehensive services and referrals, to pregnant adolescents by Title X family planning clinics will have a deleterious effect on our society's most disadvantaged teenagers, and, in many

cases, on their children.

2. The DOOR is a multi-service center for young people from ages 12 to 21, serving the New York City region from its location in lower Manhattan. Founded in 1972, The DOOR is a nationally recognized model program for providing comprehensive services to young people. Among its many awards, The DOOR received the 1987 Society For Adolescent Medicine Hilary Miller Award for Innovative Approaches to Adolescent Health Care, and was chosen by Nancy Reagan's Drug Abuse Fund as one of two funding recipients for 1987. The history and background of The DOOR are set out in detail in the brochure attached hereto as Exhibit B.

3. Among The DOOR's services is a health center staffed by consultant physicians, nurse practitioners, nurses, social workers and other health professionals. The health center provides primary care to over 3,200 young people annually, many of whom have no other source of health care. Other services include nutrition, social work, psychological counseling, education, career counseling, legal services and a full range of creative and recreational workshops. One of the keys to The [DOOR]'s success is its ability to provide on-site referrals from one service to another. Thus, a teacher can easily refer a young person to the social work or other department by accompanying the young person to the appropriate service.

4. In the health center, our caseload includes large components of family planning, pregnancy verification, perinatal and well-baby care. Funding for these programs is provided in part by Title X, New York State Family Planning Grants, and other governmental and private grants and donations. During my 15 years at The

DOOR's health center, I have had occasion to be directly involved in, and to observe, the provision of these health care services to thousands of young people. Many of these young patients have no other place to which they can turn for information and support regarding their family planning and other health care needs. Many of these young people enter The DOOR's health care program and other programs through its family planning component, and our professional staff are thereby able to detect a number of serious health care and other problems that would not otherwise have been found.

5. As patients, young people present unique treatment problems not presented by adult patients, and assumptions about the behavior of adult patients cannot simply be projected onto the care of young people. Moreover, the capacity to provide comprehensive counseling and referrals on all of the issues raised by a pregnancy is extremely important because teenager[s] lack information and support. Pregnancy causes a crisis which could lead to extreme problems (e.g., suicidal ideation which requires psychological evaluation and counseling). To the extent the regulations inhibit such counseling and referrals, they will have a negative impact on many teenagers.

6. We have observed over the years that many young people lack the motivation and/or ability required to be effective health consumers. They tend to require extensive follow-up to ensure compliance with even the simplest prescribed treatment regimes. In the case of complex treatments for which we lack the appropriate facilities, we must refer young people to other providers, generally hospitals. Even when a referral is made to a particular clinic at a specified hospital (e.g., for a sonogram at X Hospital), many young people encounter

obstacles to treatment at such institutions and seek our assistance. Any inhibition of our ability to assist young people in this situation could have negative consequences for the health of the young person.

7. Based on my many years of experience treating adolescent patients, it is my professional opinion that incomplete referrals to a list of general providers, as are apparently called for by the challenged regulations, will in the majority of cases, result in a significant delay in treatment, and in some cases a lack of treatment altogether.

8. The DOOR and other adolescent family planning programs are successful because young people know that they can trust and rely upon the professional staff for unbiased counseling and treatment, and for complete and accurate information. To the extent that the regulations prohibit providers from answering certain inquiries by patients concerning all of the issues raised by a pregnancy, young people's faith in the medical profession and their likelihood of continuing treatment (pre-natal care, etc.) following referral recommendations will decrease as well resulting in harm to the young person's health. Moreover, young people would stop turning to The DOOR and other providers for health care, and thus serious problems might go undetected.

9. In the case of pregnancy and perinatal care, any delay in establishment of a relationship with the appropriate provider can have important negative consequences on both maternal and infant health. Numerous studies have established the correlation between early perinatal care and infant health. The children of teenagers are most likely to be low birth weight and to have other serious medical problems. Yet,

early perinatal care can greatly decrease these risks.

10. Up to the promulgation of the challenged regulations, the Title X program and other federal programs have recognized the importance of comprehensive services and of medically appropriate referrals. The challenged regulations' reduction of all pregnancy-related referrals to handing a pregnant young woman a list of general providers is impractical in the context of the adolescent patient, for the reasons already noted. Thus, it is not difficult to postulate that the challenged regulations' inhibitions of pregnancy-related care referrals will contribute to an increase in low birth weight babies and other negative outcomes of teenage pregnancies.

11. For the reasons stated herein, I respectfully urge that implementation of the challenged regulations be enjoined so that the Title X program can be refocused on the most important aspect of its statutory purpose: making comprehensive, high-quality family planning services available to young people in the most effective manner.

/s/
Michaele White

Sworn to before me this
15th day of December, 1987

EXCERPTS FROM AFFIDAVITS

MARILYN BENNETT
Executive Director of Health Services of Hudson County, New Jersey ("Hudson Health")
February 5, 1988

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7. Jersey City, in which Hudson Health is located, has a population of approximately 23,532 people. Of this population, approximately 25.9% are below the poverty line.[1] The infant mortality rate in Jersey City is the second highest in the state. In fact, Jersey City's infant mortality rate far exceeds that of most Western nations in the world and points to the compelling need for quality health and family planning services in Jersey City.[2]

8. Hudson Health provides services to approximately 9,000 women per year. Of these patients approximately 30% are teenagers and 85% are medicaid eligible. * * * There is no other comparable medical facility in Jersey City.

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[1] Figures are from 1980 Census reports for Jersey City.

[2] According to the New Jersey State Department of Health, Jersey City's infant mortality rate for 1983 was 20.4. Compare with rates of 12 for the United States and the United Kingdom, and 10 and 13 for France and the Federal Republic of Germany, respectively. See World Health Statistics 1984, World Health Organization, United Nations.

24. Moreover, our philosophy of providing integrated services will be undermined by the separation requirement of the regulations. Hudson Health recognizes the benefits for women of the availability of counseling and the means of obtaining all reproductive health options at a single health center. Provision of comprehensive integrated services results in higher quality health care for women and encourages awareness among patients of the connection between responsible family planning, planned pregnancy, early prenatal care and healthy babies, as well as the relationship between uninformed or careless birth control habits and unwanted pregnancy.

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RUTH KLEPPER
Executive Director of Upper Hudson Planned Parenthood ("UHPP")
February 5, 1988

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16. Approximately 26 per[cent] of our clients visit a UHPP clinic for the first time because they suspect that they are pregnant. Indeed, because pregnancy or family planning/contraceptive needs are of immediate concern to most women of reproductive age, they are likely to seek health care for these concerns first. UHPP currently provides these women with comprehensive health care and education for their reproductive needs, thereby enabling women to take charge of their own health and obtain appropriate health care. Without the comprehensive exams, counseling and referrals we provide, many women would not identify their health problems or receive appropriate treatment because they have chosen

not to, or have been unable to access routine health care.

17. During 1986, 18 percent of our patients were diagnosed as pregnant. Of these, 72 percent requested referrals for abortion services. After discussions and counseling with our professional staff, UHPP provides the patient with detailed referral sheets that enable her to contact an appropriate provider.

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ROBERTA MERRENS
Executive Director of Northern Adirondack Planned Parenthood ("NAPP")
December 22, 1987

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5. 76% of our patients receive subsidized services at our clinic -- services which are either free of charge or on a sliding scale basis. No other provider of family planning services in this area provides these services at no cost or on a sliding scale basis. The nearest providers of subsidized family planning services who would serve this population are one and a half hours away by ferry in Vermont or one and a half to two and a half hours away by car on roads covered by snow 6-8 months of the year. For many [of] our patients, a visit to NAPP is their first entry into the health care system; indeed, for some, it is their only source of regular health care.

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15. Without the benefit of discussion, many of our patients -- particularly our teens and adolescents -- will

be unaware of the choices available to them. I cannot overemphasize that many women we serve do not know that abortion is a safe and legal option to unwanted childbearing.

16. Furthermore, many women seeking abortions are unfamiliar with the procedure and of the greater health risk associated with obtaining an abortion after the first trimester. Under the regulations, our counselors will be precluded from telling their patients of this health risk and from encouraging the patient not to delay in getting the abortion. In addition, providers of abortion services are located at varying distances from our clinic. Without advice as to the proximity of providers, many women will travel needlessly long distances -- on roads covered by snow much of the year -- to procure an abortion. As a result, many of our patients may obtain abortions at a later time than they would if we counseled them, thereby increasing the danger to their health.

17. The regulations bar NAPP from counseling a woman regarding abortion even if she is at risk if she continues her pregnancy. This bar exposes our clients to grave health dangers; unaware of the necessity of obtaining an abortion, many women will dangerously continue the pregnancy, placing themselves in a life-threatening situation. Others may seek an abortion, but will not realize the necessity of doing so quickly. Finally, others may seek an abortion but may encounter health endangering delays as a result of the counselor's inability to tell the patient of the closest providers. These health dangers are not lessened, as the regulations suggest, because we are permitted to refer the woman to a medical specialist who can treat her illness and who can advise her regarding potential health risks. Rather, this additional referral -- instead of direct referral to an

abortion provider -- simply builds in an extra level of delay.

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KATE D. POTTEIGER
Director of Planned Parenthood of Tompkins County ("PPTC")
December 15, 1987

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9. Teens are often referred to PPTC through the Suicide Prevention Counseling Service. If a teen contacts the Line, she would most likely be referred to PPTC for testing and/or counseling. Many of the teens we counsel choose abortion after extensive non-judgmental, non-directive counseling, and are referred for that service. I would estimate that 5 10-14 year olds were referred for abortion and 137 15-19 year olds were referred for abortion in 1986.

10. Women suffering from a variety of medical disorders are at risk if they continue their pregnancies. I would estimate that 10-12 patients a year with medical problems are referred for abortion, perhaps one-third to one-half of whom are on Medicaid. For example, we have referred a woman with AIDS for abortion, as well as a woman with a past history of cancer; a woman with psychiatric illness under medication; an IV drug user and a woman with moderately severe cerebral palsy. We refer one or two patients per year who are suffering from ectopic pregnancies. We refer one or two patients a year for abortion who have been raped.

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